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AUTHOR	Nigam, Linda; And Others
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ABSTRACT

This manual, which is intended for use in conducting individualized inservice training sessions for certified nurse aides employed in nursing homes and boarding homes throughout Maine, contains three sections of learning experiences designed to help health care workers better understand and deal with "difficult" behavior on the part of residents in long-term care settings. Presented first are an introduction that discusses the context in which the manual was developed; explanation of the process-oriented approach adopted in the manual; and description of key characteristics of adult learners. The following topics are covered in the three sections of inservice materials: basic human needs (Maslow's hierarchy of human needs, self-esteem and behavior, admission to long-term care, relocating residents, universal human needs, human needs, getting needs met); factors contributing to problem situations (defining difficult behavior and understanding manipulative, difficult, and aggressive/assaultive behavior); understanding the communication process (communication, knowing residents, problem solving, caregivers). Each section contains some or all of the following: session overview; background information; learning experiences; handouts, worksheets; discussion sheets; discussion questions; instructor's guidelines/notes; case study; assessment guide; and student handouts. Thirty references are listed. Appended are a sample 3-hour training format and activities about Alzheimer disease. (MN)

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Geriatric Education and Resource Outreach

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"Understanding Difficult Behavior"

A TRAINING MANUAL

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State House Station #40
Augusta, Maine 04333
(207) 289-4230

Understanding Difficult Behavior

A Selection of Learning Experiences
Designed for Staff in
Long Term Facilities

Authors:

Linda Nigam, RN MS
Norman McCauley, LSW, MSHS
Virginia Mallory, RNC

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We would also thank the caregivers we have had the priviledge of working with through the GERO program. Their willingness to share their thoughts, experiences, and concerns was a significant contribution to both the content and spirit of this collection.

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UNDERSTANDING DIFFICULT BEHAVIOR

TABLE OF CONTENTS:

Introduction.....1
Statement of Purpose.....2
The Adult Learner.....3
Philosophy.....4

Section I.....5
A Consideration of Behavior
Basic Human Needs

Maslow's Hierarchy of Human Needs.....6-12
Self-Esteem and Behavior.....13-14
Admission to Long Term Care.....15-17
Relocating a Resident.....18-19
Universal Human Needs.....20
Human Needs.....21-23
Getting Needs Met.....24-28

Section II.....29
A Consideration of Difficult Factors
Contributing to Problem Situation

Defining Difficult Behavior.....30-32
Understanding Manipulative Behavior.....33-40
Understanding Difficult Behavior.....41-46
Agressive/Assaultive Behavior.....47-56

Section III.....57
A Consideration of Understanding Communication

Communication.....58-66
Knowing the Resident.....67-75
Problem Solving.....76-80
Caregivers.....81-86

Bibliography.....87-88

Appendices
I - Three Hour Training Format.....90-95
II - Alzheimers Disease: Activites.....96-98

UNDERSTANDING DIFFICULT BEHAVIOR

INTRODUCTION

This manual is a sequel to the training manual, **TOPICS IN AGING AND MENTAL HEALTH**, written in 1989 under a federal grant from the Administration on Aging. It is produced with funds from the State of Maine Department of Mental Health and Mental Retardation, Bureau of Mental Health.

The manual consists of a selection of the most effective learning experiences developed by the instructors for the Geriatric Education and Resource Outreach Program. GERO, a service funded by the Bureau of Mental Health, provides inservice education programming to staff in residential care and nursing care facilities throughout a twelve county area in Maine.

The program, upon which this manual is based, was designed to assist caregivers in understanding possible reasons for some of the disturbing behaviors they encounter as they go about their caregiving activities. This understanding is critical to developing more therapeutic approaches and helpful interventions. While the program emphasizes the importance of knowing the resident, it places equal importance on the "self-awareness" of the caregiver. Through a variety of learning experiences, participants gain awareness of the power of their verbal and non-verbal communication and the significance of their relationship with the resident.

The GERO instructors presented the program as a four part series, later expanded to five to include a final session on caring for the caregiver. We found that the success of the program depended on the willingness of the participants to actively participate in the sessions. This was promoted by requesting that participants commit to attending all of the sessions. The atmosphere was kept informal to encourage an interactive learning experience. Small group process provided the milieu for active problem solving. An every week, or every other week schedule offered the necessary continuity.

Recognizing that you may not choose to do a series of programs, we have arranged the learning experiences so that you may design your own program to best meet the needs of your staff. We have organized the materials into basic topic areas, moving from the general areas of understanding needs common to all people, to the more specific needs of the mentally impaired elderly, and finally, to communication as the key to problem solving in the long term care facility.

You can support the educational process by providing a comfortable and private room for the programs. A VCR may be needed should you wish to use the videos referenced. If you decide upon a series format, certificates of completion presented to those attending the entire program are a meaningful recognition.

STATEMENT OF PURPOSE

We have developed this manual as a "process" oriented approach to understanding difficult behavior in the long term care facility. Our belief is that as staff better understand basic human needs, demonstrate a respect for those needs, and, in fact, try to meet those needs in the long term care setting, they will experience fewer "difficult behavior" situations. Of course, every facility has residents who are challenged with psychosocial, emotional, or cognitive problems that are beyond the scope of this basic manual, requiring more involved and specialized care planning. None the less, the understanding that develops from participating in the learning experiences presented in this manual can serve as the foundation for the care required by the more impaired residents.

There are many excellent resources available to provide background information for participants. We have included a complete bibliography of references used in this manual. We believe that the material included in the previous GERO training manual, Topics in Aging and Mental Health, provide background that can supplement and enhance the learning experiences included herewith.

THE ADULT LEARNER

The use of this manual should provide an opportunity for your staff to increase their knowledge level and skills in the care of the elderly resident with mental health impairments. Because of it's design and approach to learning climate, we hope it will also serve to increase staff involvement in the team effort needed to provide care to the residents of your home.

You will note as you examine the manual that many opportunities are provided for staff at every level to actively particpate by sharing their thoughts and experiences. This type of approach is generally successful when working with the adult learner. It may be helpful to review these principles of adult education:

1. Adults bring with them to the class valuable knowledge, skills, and experience they have gained. Many learners, in a supportive environment, are willing and anxious to share their experiences with the group. It can also be reassuring for you as the facilitator to know that the resources available to the group are not limited to those that you have. You will often have collective insight from which to draw. Part of your role as facilitator is to know which contributions are therapeutic and which are not and to assist the group with the process of validating useful information and disregarding the rest.

2. New lessons can be learned by reflection upon one's life and work experience. This is a part of the learning process in these workshops. Not only will valuable insight be gained, but people will feel more involved in the learning experience.

3. Adults learn best when they feel the content is useful to them. They want and need to relate what they learn in the classroom to what they do on the job or experience in their personal life. While some new theory and knowledge is essential to each new learning experience, ways to apply this material to specific tasks at hand is the essential part of the program.

WE BELIEVE THIS TO BE TRUE

There are a few basic beliefs about behavior that form the foundation for the learning experiences described in this manual. The first is that all behavior has meaning. The meaning may not be immediately obvious, even to the person acting out the behavior. The challenge to the caregiver is to remain open minded and seek to understand the meaning of the behavior.

A second belief is that people, ourselves included, often do not ask for what they really want or need. The words we use, or the way we behave, may not accurately reflect our true desires. What we sometimes define as "difficult behavior" may be an individual's attempt to meet the basic human needs of affection, control, and security - often difficult to do in a long term care facility.

The final belief is that the only behavior we can ever hope to change is our own. It is less helpful to speak of how we can change a resident's behavior and far more productive to consider how we can change our response to this person. The more we know and understand our own responses to a troubling situation, the more able we become to handle ourselves in a safe, effective, and therapeutic manner.

SECTION I

A Consideration of the Behavior in "Understanding Difficult Behavior"

Basic Human Needs

This section opens with a brief overview of human needs as defined and described by psychologist Abraham Maslow. Through the learning experiences, participants are challenged to identify human needs that are common to all of us, and to consider how life in a long term care facility can influence the meeting of these needs for the residents. The final experience provides an opportunity for staff to "walk a mile" in a resident's shoes."

CONTENTS Page

Maslow's Hierarchy of Needs:
- Background Information....6
- Learning Experience....7
- Handout....8
- Worksheet....9
- Discussion....10-12

Self Esteem and Behavior....13-14

Admitting A Loved One to Long Term Care
- Instructor's Guide to Learning Experience....15
- Learning Experience....16
- Worksheet....17

Relocating a Resident....18
- Handout....19

Universal Human Needs
- Learning Experience....20

Human Needs
- Learning Experience....21
- Discussion Sheet....22
- Instructor's Guide....23

Getting Needs Met
- Learning Experience....24
- Guidelines....25
- Discussion Questions....26
- Instructions....27-28

UNIVERSAL NEEDS
MASLOW'S HIERARCHY OF NEEDS

BACKGROUND INFORMATION:

One model of studying basic human needs is psychologist Abraham Maslow's **Hierarchy of Human Needs** which he based on normal behavior and motivation. The model is graphically arranged in the shape of a pyramid (see handout). Needs are identified at five levels. At the base of the pyramid are physiological needs, followed by the need for safety and security, the need for belonging and affection, for self esteem and respect, and finally the need for what Maslow refers to as "self actualization".

Maslow further theorized that we must meet the needs at the base of the pyramid before we move on to meet any higher level needs. For example, if one were extremely thirsty, one might go to even dangerous lengths to satisfy the need for fluid. The need for fluid would be more powerful than the need for safety. Having satisfied that basic need, the individual would be more inclined to consider higher level needs. In general, when basic needs are satisfied, people are motivated to take on new challenges and risks that increase opportunities to move up the pyramid. People who are independent and have control over their choices can make the decisions that are necessary to continue personal growth. Individual status can increase through behaviors that are acceptable to society and appropriate to the circumstances.

Caregivers in long term care facilities may find it helpful to consider how the realities of living in a long term care facility affect a resident's ability to get these needs met. This discussion can help caregivers discover how much of resident time and behavior is devoted to getting these needs met.

MASLOW'S HIERARCHY OF NEEDS
LEARNING EXPERIENCE

OBJECTIVES: Participants will discuss specific resident care situations in relation to Maslow's Hierarchy of Needs.

Participants will describe care strategies that assist residents in securing their human needs.

METHOD: Provide each participant with a copy of Maslow's Hierarchy of Needs and a worksheet.

Begin the inservice with a general discussion of the types of needs Maslow identified, using examples wherever possible (see Instructor Notes). Relate this discussion to the needs of caregivers themselves. Ask how they feel when their needs are not met. Does their behavior change? How?

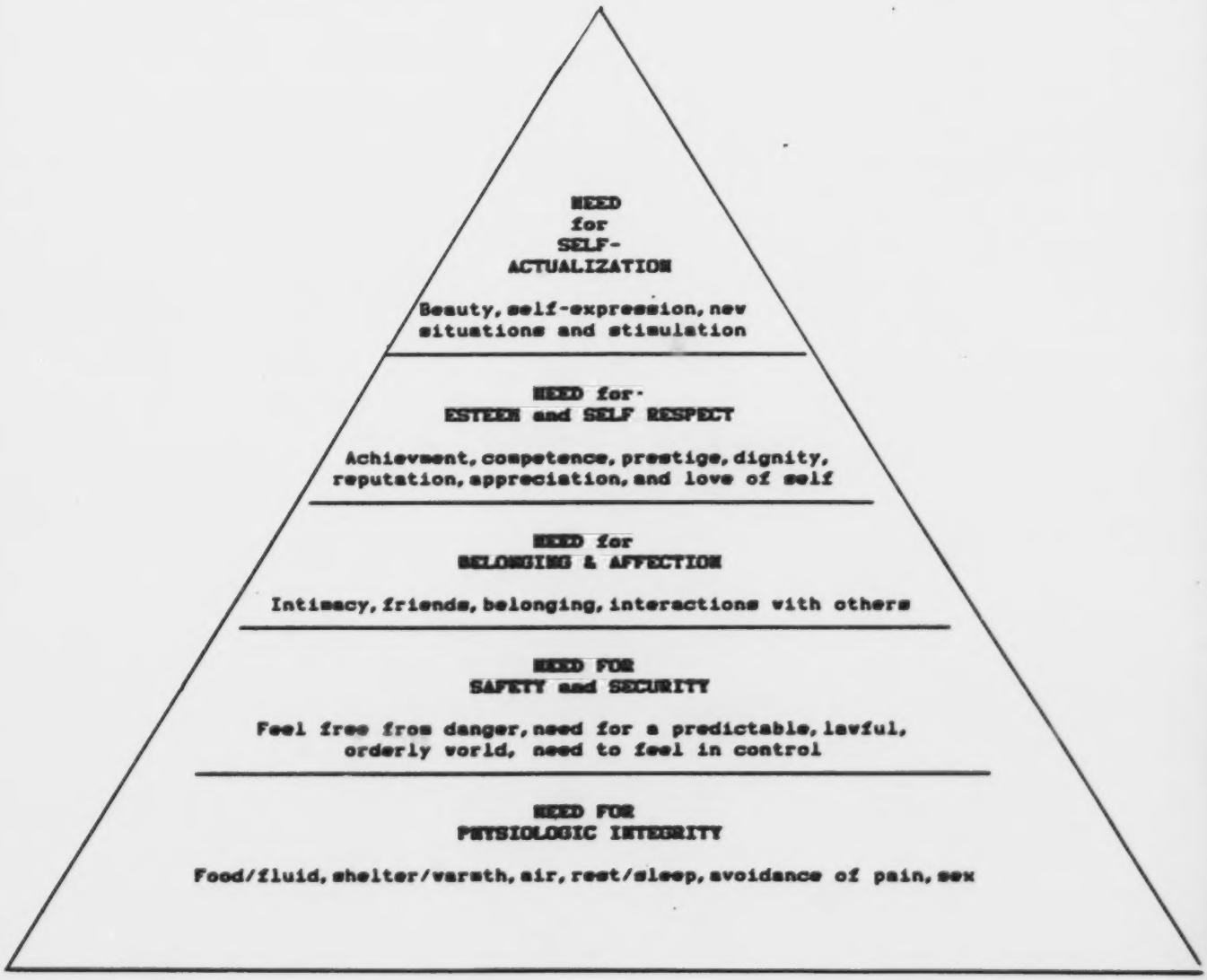
Next ask that each consider caregiving situations they have experienced where they felt the needs of the resident may have not been met. What were some of these needs? Why did they suspect that needs were not being met? What was done that helped? That did not help? How would they do it differently now?

You may wish to divide larger groups into smaller working ones. Each group records their thoughts which are later reported to the entire assembly. A flipchart is helpful for recording purposes.

Instructor Note: You may wish to review the Discussion notes, or provide them as handouts to each participant.

HANDOUT

ABRAHAM MASLOW'S HIERARCHY OF NEED


NEED
for
SELF-
ACTUALIZATION
Beauty, self-expression, new situations and stimulation
NEED for
ESTEEM and SELF RESPECT
Achievment, competence, prestige, dignity, reputation, appreciation, and love of self
NEED for
BELONGING & AFFECTION
Intimacy, friends, belonging, interactions with others
NEED FOR
SAFETY and SECURITY
Feel free from danger, need for a predictable, lawful, orderly world, need to feel in control
NEED FOR
PHYSIOLOGIC INTEGRITY
Food/fluid, shelter/warmth, air, rest/sleep, avoidance of pain, sex

This diagram is meant to identify basic human needs. It may be helpful to reflect upon when caring for people who are unable to express their needs verbally. Generally, the needs at the base of the pyramid must be met before higher needs can be satisfied.

WORKSHEET

UNDERSTANDING RESIDENT NEEDS

Using the information on the Hierarchy of Needs handout and discussion information, choose a resident and identify what you feel his/her needs are. Identify a resident need under <u>each</u> heading. It is understood that your decision about need may be based on your knowledge of the resident and on observations you made while caring for this resident.

HIERARCHY OF NEEDS	RESIDENT NEEDS
<u>PHYSIOLOGICAL</u>	
<u>SAFETY AND SECURITY</u>	
<u>BELONGING</u>	
<u>AFFECTION</u>	
<u>SELF-ESTEEM</u>	
<u>SELF-RESPECT</u>	
<u>SELF-ACTUALIZATION</u>	

DISCUSSION OF MASLOW'S HIERARCHY

INSTRUCTOR'S NOTES:

Physiological Needs:

If hunger and warmth are unmet needs, it becomes impossible to think about safety or self-esteem. All our energy is directed to securing food and heat. In fact, our survival depends upon our doing this. A resident who is cold and unable to verbally communicate this may non-verbally express this need by increased pacing, by taking something that is not theirs, or by becoming more agitated. Behavior becomes the method of expressing the need, though the behavior may not be directly related to the need. Another basic need that is often compromised in the long term care setting is sleep. Without adequate rest and sleep, people can become restless, agitated, and disoriented. Sleep may be interrupted by an emotional upset, disease, medication, fear, or the environment. Poor vision may cause shadows or poor lighting create images that are strange or threatening.

An appropriate and available outlet for sexual expression is often an unmet need in long term care facilities. Additionally, some kinds of mental impairments affect the social controls most people follow regarding sexual behavior. Exposure or masturbation in a public area can threaten the feelings of safety for other residents.
The need for food, fluid, shelter, warmth, air, rest, sleep, sexual expression, and freedom from pain are powerful needs. People will resort to desperate means to secure these needs. If unable to express these needs verbally, they will be acted out in behaviors. Aggression, anger, frustration, stealing, hoarding, pacing and wandering may be ways that these needs are being communicated. It is the challenge to caregivers to know the people they care for well enough to understand the residents non-verbal cues that their basic needs are not being met.

Safety and Security Needs:

Safety and security mean different things to different people. To a commuter, it might mean arriving home safely after traveling through a blizzard. To a person living in a long term care facility, it probably means knowing that staff are nearby to answer a call bell or to help with daily needs.

We all need to expect certain things to occur in a timely way. Some predictability contributes to our feeling of security. For example, we expect to get our paycheck on a specific day. If we do not, we might become anxious and imagine all kinds of negative possibilities. Predictability is equally important to the people who have come to live in your home. It contributes to their own sense of safety and security. You may have noticed that routines are extremely important to some of your residents.

When people move to a long term care situation, they have left the security of a familiar environment. They may also have given up a great deal of control over decisions affecting their lives. They must rely on staff to meet many of their personal needs. This loss of control is an ongoing threat to safety and security. Trust between caregiver and care receiver is essential to enhance feelings of safety.

Some threats to safety are not based on reality but on misperception. For example, the mentally impaired person may perceive your help in toileting to be a personal assault and will respond appropriate to his perception.

Safety and security needs also include knowing that someone is concerned about you and cares about your feelings. A touch, a hug, a caring word, or simply listening can convey feelings of comfort and security.

Need for Belonging and Affection:

Most people need and want to belong to a group. People will seek ways to be with others whether for happy times or difficult times. For example, staff members have a place to go on breaks to be together, to share problems or events. Family, friends, work groups, social clubs, churches are all examples of how people seek to belong. It is natural to seek others with common interests and concerns. It is comforting to share with others life experiences in order to have a balanced point of view and to know that we are not alone; to know that others understand our feelings and needs at times of great sadness and great joy and are willing to listen to us.

The opportunity for sharing and support among residents may be missing in the long term care facility. Moving away from their home can create a distance, both physical and psychological, between residents and their friends and family. It may be difficult for the cognitively intact resident to find someone in the home with whom they can communicate.

Need for Self-Esteem and Self-Respect:

Significant amounts of long term care staff time and energy is involved with meeting the first two levels of need as we have described. Satisfied physiological and safety needs are essential so that people can assume the challenge of meeting the higher needs described by Maslow.

Self-esteem may be described as the value people place on themselves and their ability to influence others with their thoughts, ideas, and knowledge. It involves a meangingful relationship with the people, space, and things in their world. One's sense of self-esteem influences how one interacts with the world. Physical appearance, accomplishments, status in one's family, community, work and social groups, and the respect that comes with this contribute to an individual's self-esteem and self-respect. Consider how you felt when you were recognized for the quality of care you give.

In long term care settings, the opportunities for residents to enhance their sense of self-esteem are more limited than in the larger world. Nonetheless, they do exist and staff can be instrumental in seeing that they are not lost. Listening to residents, recognizing the value of their accomplishments, reminiscing, and valuing their present and past accomplishments can help to foster a positive self-esteem and respect. Statements such as "I have succeeded in doing what I wanted to do and I did a pretty good job" or "I believe I am able to walk the length of the corridor today" or "I think my idea about what I will wear today is appropriate" are all statements that illustrate how residents can find positive self regard in their current situation.

Remembering and talking about one's life and accomplishments can also raise self-esteem. The resident who repeats stories about the past is affirming that their life was important and that they made contributions to society. Acknowledging these contributions and encouraging these stories are positive things that staff can do to maintain the residents' positive feelings about themselves.

Fostering positive self-esteem can also mean appreciating others just for being the person they are. Perhaps they have a special sense of humor, are especially good listeners, or have beautiful hands. Affirming these special qualities and abilities can enhance self-esteem. Perhaps a sign of a healthy self-esteem in all of us is wanting to be as indpendent as possible yet having the courage to ask for assistance when needed.

<u>Need for Self Actualization</u>:

One description of self actualization might be growing as a creative and thinking person. Opportunities for personal growth and enrichment are essential to meeting this need. Consideration of the meaning of life, the meaning of death, leaving legacies for future generations are all part of the self-actualization. Long term care facilities can provide opportunities for people to be part of this process. Some examples of legacies include photo albums, scrapbooks, written memoirs, taped memoirs, paintings, genealogies, personal possessions, and skills passed on to future generations. Learning, thinking, discussing, creating are all part of life that is available to all of us. These opportunities can be part of the environment in long term care using the creative talents of staff and residents desirous of having the highest quality of life.

SELF-ESTEEM AND BEHAVIOR

Most of us can vividly recall the picture of the young man who put his life on the line by standing in the path of a military tank during the student protests in China. Ordinary people do extraordinary things to protect loved ones, belongings, or principles that are valuable to them. There is a general agreement among those who make human behavior their field of study, that most of the difficult behaviors that caregivers deal with are residents' attempts to defend or protect their most valued possession, their self-esteem.

> Webster defines SELF-ESTEEM as "a confidence and satisfaction with ones self; self-respect; self-conceit."

Elders are particularly vulnerable to the many changes and losses that undermine the mental image they have of themselves. Avery Weisman was certainly correct when he stated, "Self-esteem is not only fragile, but needs renewal".

Self-esteem, where do we get it?

The primary vehicle by which we develop self-esteem is our relationship with other people. The way others view us actually becomes the mirror through which we develop a perception of ourselves. Establishing therapeutic relationshipos with our residents is therefore essential to building their self-esteem.

Who is involved?

In a team approach to working with the mentally impaired residents, it is assumed that every relationship between resident and a staff person, from administrator to ward clerk has the potential for being a therapeutic relationship.

How?

There are three basic components to all therapeutic relationships. These are - **inclusion**, **control** and **affection**.

Inclusion

Inclusion conveys membership, involvement, closeness. It is the opposite of exclusion. For example, an aid who talks to a speech impaired resident while helping her dress (despite the fact she cannot respond verbally) is including her in the relationship.

"One way to show disrespect and low regard for elders is to exclude them from our interactions. How do we exclude elders, let us count the ways:

1. we exclude them from our empathy and tenderness.
2. we exclude them by not listening to them.
3. we exclude them from interviews, assessments, talk in front of them, or direct questions to significant others.
4. we exclude them from making decisions (of all types).
5. we exclude them from mutual planning in health care goals.
6. we exclude them from advisory boards and committees.
7. we exclude their advise.
8. we exclude them (especially demented, depressed individuals) because they are not very interesting.) Burnside, (1988)."

CONTROL

Conveys an influence on things and people in one's environment. Without feeling some measure of control, people are not motivated to continue functioning at their highest level. They may regress and behave like infants. For example an aide who while feeding a resident, says to her, **"Do you want to eat your dessert now or do you want to eat it a little later?"** is providing the resident some measure of control over her life.

Affection

Everyone needs to feel cared about, to feel valued and appreciated. For example, an administrator who smiles at residents and chats with them for a few minutes is showing both affection and inclusion.

In many ways, you are a role model to your residents. They may learn from you helpful ways of communicating by observing your verbal and non-verbal interactions with other staff and residents.

Source: OUTREACH, Spring 1990

INSTRUCTOR'S GUIDE
ADMITTING A LOVED ONE TO LTC
LEARNING EXPERIENCE

BACKGROUND INFORMATION

Adjusting to a new situation or environment can create stress and anxiety especially in the older person who has had to cope with change, illness and loss. Others may step in and take away even more control and create more change in that person's life. When admission to a LTC facility is required the demands on all can be overwhelming. Because of the limited time or the stress of the situation, staff may not learn that there are certain characteristics, personality traits, or likes or dislikes the elderly person has. Having this information would assist staff in providing better care.

For example, Mr. Smith is admitting his wife after a long illness at home. He is scared and overwhelmed himself. She is depressed and has suffered a stroke and is unable to speak well. A concern for him is her pride in how she is dressed and how her hair looks before anyone sees her. Everything must be just right and certainly clean. She has always been very meticulous in this area.

Another concern is whether she will be allowed to take as much time as needed to eat. She is able to feed herself but all her life she has taken her time, eaten slowly and in a certain way. Even as a young mother and wife she would counsel her family to take time in eating. This could be considered a pet peeve of hers. It upset her when people hurried.

Every individual has a sense of what is important to them. Conflict occurs when staff do not give the same importance to these needs.

In becoming acquainted with a resident, staff should remain alert and listen for clues that can lead to a better understanding of who this person is.

LEARNING EXPERIENCE
ADMITTING A LOVED ONE TO LTC

OBJECTIVE: **Through a simulation of admitting a loved one to a long term care facility, participants will discuss the kinds of personal information that staff should know to facilitate the adjustment process.**

METHOD:

Some of us may have to think about admitting a loved one to a nursing care facility. You may have already had this experience. The emotional and mental health care of the person must be considered. The identity of that person, those special characteristics, traits and experiences that make each of us a unique individual, must be identified and respected in planning care. For this experience, consider what you would want staff to know about the person you are admitting.

Consider the following as you think about that person and write down information which could be helpful to the staff in making the adjustment easier, more comfortable and less stressful to your loved one.

- Attitude about life and values
- What upsets and what calms this person
- Special food likes and dislikes
- Personality traits such as humor, quiet, laid back, easily upset, loner, stubborn, etc.
- Life style. Social, close or distant from family, special family member or friend
- Is this person meticulous and fussy about appearance or just generally casual?
- What is important to this person such as hobbies, interests, relationships, special time of day?
- Is this person organized about personal things?
- What will be missed most because of change? i.e. sound of traffic, children, ocean
- Any pet peeves or annoyances
- Any special days that have meaning only to this person. Anniversaries or birthdays

These are a few ideas to get you started. There may be others that you will think about. Be sure to include them. It might be interesting to use yourself in the above exercise!!

WORKSHEET
LEARNING EXPERIENCE

ADMITTING A LOVED ONE TO LTC

Using information and ideas from Exercise #2, list according to heading the ideas and insight you have about the person you are admitting to LTC.

ATTITUDE | FEELING | TRAITS | LIFE STYLE

PET PEEVES | SPECIAL DAYS | WHAT UPSETS

WHAT CALMS | FOOD LIKES/DISLIKES | HOBBIES/INTERESTS

WORK EXPERIENCE | SPECIAL EXPERIENCES

SPECIAL RELATIONSHIPS

RELOCATING A RESIDENT

Relocating a resident is often necessary to provide more appropriate care or to secure a safe environment. Sometimes a resident is moved to another facility, but, often, the move is to another area of the home.

Relocating can be a traumatic event, causing increased emotional stress to the residents involved, and to staff as well. Remember that relationships have been established in the present surroundings. Even if they were not all positive ones, they were a predictable part of life in that location. Familiarity with an area contributes to a sense of security and feelings of safety. This will be threatended with a move to a new place. Feeling a lack of control over this whole process also heightens anxiety.

Several things can be done to help make the relocation process easier. The following handout, through a series of questions, indicates the many things that can be done to make the process a more positive experience for residents and staff alike.

HANDOUT

RELOCATING A RESIDENT

Relocating a resident can create anxiety and confusion. Before a move is made it is helpful to not only plan carefully but to consider the following:

1. First, is the move <u>really</u> necessary?
2. Does the move involve leaving a close friend or confidante? This may include a staff member whom the resident trusted.
3. Will the change have a positive or negative impact on the relocated person?
4. If physically able, is resident able to see the new location before being moved?
5. Is the information regarding the move completely honest?
6. Are special personal items, the "security blankets", to be moved with the resident?
7. Are new caregivers informed about the special needs, idiosyncrasies, and wishes, of the residents?
8. Will follow-up visits be made by former caregivers after the move?

A team meeting to discuss the above questions should be held and involve present and future caregivers. If the resident is able to participate, he/she or a representative should be included. Above all, be honest with the resident to be relocated.

Adapted From: Burnside, 1988.

UNIVERSAL HUMAN NEEDS
LEARNING EXPERIENCE

OBJECTIVE: To sensitize participants to universal human needs and the influence of institutional life on the meeting of these needs.

To discuss how the caregiver can support these needs being met.

METHOD: Participants sit at tables in groups of five or six. There should be a large sheet of newsprint and a marker at each table.

Participants are instructed as follows:

Life circumstances have compelled you to enter a nursing home. For you, personally, consider what your environment must include in order for you to feel good about yourself and be a relatively happy person. Use the next five minutes to identify your needs and have one person write all the needs of the group on the newsprint. Please write large enough for the entire large group to see.

DISCUSSION: When the groups have completed the task, ask each group to share their list, encouraging discussion of differences and similarities. Encourage participants to compare their needs with those listed on the Human Needs handout on page 22.

Ask the group to consider how life in a long term care facility undermines a person's ability to meet these needs. Note, on a piece of newsprint, their suggestions for caregiving interventions that help residents fulfill some of these needs.

NOTE TO INSTRUCTOR: You may find the Instructor's Guide to the Human Needs discussion a useful resource for this exercise (p23). The material entitled SELF-ESTEEM AND BEHAVIOR is useful background as well.

HUMAN NEEDS

LEARING EXPERIENCE

OBJECTIVE: To discuss how living in long term care facilities influences the fulfillment of basic human needs.

To consider possibilities for change.

One of the goals of the Difficult Behavior Training program is to highlight the similarities between staff and residents rather than the differences. Sometimes, behavior that is regarded as "difficult" by staff is a resident's response to basic human needs not being met rather than a symptom of a mental impairment. The **Human Needs Discussion Exercise** is a valuable tool to illustrate this point.

The human needs described in this experience are those identified by Elaine Grace Boettcher(1983) in the article "Preventing Violent Behavior". She refers to them as biopsychosocial needs that, when left unmet or when threatened, will stimulate a behaviorial response by the resident. The type of response will likely reflect the prior coping style of the resident.

METHOD: Provide each participant with a copy of the Human Needs discussion sheet and ask that they complete this worksheet.

Discussion should center around the universality of the needs and how we feel when they are threatened. In small groups, participants discuss and note how life in a long term care setting influences, positively or negatively, the fulfilling of these needs. Ask participants to discuss what steps they could take in their day to day care of residents to enhance the meeting of more of their basic human needs.

HUMAN NEEDS

DISCUSSION SHEET

Human Needs	How are these needs affected by a move to a nursing care facility?
Territory: Need for comfortable space or privacy, or freedom from unwanted physical intrusion.	
Communication: Need to be able to talk to another person.	
Respect: Freedom from insults, shaming by others, stigma, humiliation.	
Safety-Security: Protection from harm.	
Autonomy: Need to make own decisions, have control over life.	
Own Time: To be able to move at one's own pace, not to be rushed or hurried by others.	
Personal Identity: Need to retain personal items and identifying material.	
Comfort: To be free from physical or emotional pain, hunger, thirst, excessive heat or cold.	
Cognitive Understanding: Need to be aware of surroundings to be free from confusion about what is happening.	

28

HUMAN NEEDS DISCUSSION SHEET

INSTRUCTOR'S GUIDE

Need	Influence of Long Term Care Setting
	Examples:
Territory	Little private space, frequent intrusions in room by staff/other residents, enter without knocking, touch, move, lose residents belongings, invade personal space for caregiving, often without asking . . .
Communication	Meaningful communication with old friends, neighbors, family may be diminished. May experience difficulty seeking and forming new relationships, cognitive ability may vary significantly from others . . .
Respect	Not being called by preferred name, vulnerable to comments by other residents, and staff, multiple losses may decrease self-esteem, being reminded of past mistakes, loss of role, prestige . . .
Safety/Security	Fearful that needs will not be met, heavy reliance on others for meeting most basic needs, bells not answered in timely fashion . . .
Autonomy	Decision making more limited. Most ADL activities decided by home and care team.
Own Time	Often encouraged to hurry, not given time to complete tasks on their own.
Personal Identity	Most personal belongings given up, what remains is misplaced, moved, handled by others. Special skills/talents may be lost. Personal choices in clothes, hair, makeup, jewelry may be diminished.
Comfort	Anxiety, change, new surroundings, new staff, impossible demands, failure in attempt to complete a task contribute to discomfort . . .
Cognitive Understanding	Many are in NH because of diminished congnitive ability. Stress produced by change, medications, physical illness, and depression, effect understanding. Hurried, stressed out caregivers increased stress, . . .

GETTING NEEDS MET

LEARNING EXPERIENCE
ROLE PLAY

OBJECTIVES:

- Experience, through role play, the losses of vision, hearing, and the ability to communicate verbally.
- Identify feelings related to dependency upon others to get needs met.
- Discuss at least three therapeutic approaches helpful when working with impaired elders.
- Discuss the significance of non-verbal communication in resident/ caregiver interactions.
- Relate this experience to prior discussions of basic human needs.

METHOD: This learning experience is based on the premise that experience is often the best and most effective teacher. The purpose of the exercise is to provide an opportunity for caregivers to step into the role of care receiver for a brief time. In the role of resident, the participant wears a blindfold to simulate vision impairment, and cotton balls in the ears to simulate hearing loss. In addition, the participant is given a list of three needs that they must communicate to their caregiver -- without speaking. This is meant to simulate the inability of many residents to verbally express their wants and needs.

Ask that participants arrange themselves in groups of three. In ea triad, there is a role for resident, for caregiver, and for observer. The exercise is repeated three times so the participants have the opportunity to experience each of the three roles. The directions for the caregiver and the observer remain the same throughout the exercise. There are three separate "needs" cards for "residents" so that each role play is different. Each participant is given the appropriate index card that carries the directions for their role.

Once they are comfortable with what they must do, encourage them to carry the exercise to completion. Some might give up after getting only one need met. Request that they continue until all three needs are communicated. After several groups have been successful, call time and ask that they switch roles within their groups. Distribute the new set of resident needs cards to the new resident in the group and have them proceed. This sequence should be completed one more time, assuring each participant has played each of the roles. Discourage discussion of what it felt like until all have completed the exercise.

DISCUSSION: This learning experience usually generates energy, sharing, and laughter. People want and need to share what the experience was like for them. After some of the energy in the room dissipates, the following questions can provide a frame work for discussion:

GUIDELINES FOR DISCUSSION LEADER

Most of the following discussion points will likely emerge from your own group interaction. They are presented here only to supplement comments made by your group.

While we can never fully understand the feelings of another, we can imagine, through role play, some of what it is like to be in another's place, if only for a short while. For example, we know that all our senses decline in acuity as we age. We are also more likely to experience diseases of the eye and ear which further limits our ability to interpret our environment. You may have found, in your role as resident, that it was very frightening to be unable to see and hear. You may have been startled when your caregiver touched you without letting you know first that she was there. You may have heard the impatience in her voice as she repeated something for the third time. Consider residents that you care for. Does your approach compensate for the limitations they must cope with each day?

We add a further dimension when we consider that many of the residents in your facility have lost the ability, through disease processes, to accurately interpret their environment. These people may not only have difficulty seeing and hearing you, but may also not understand who you are and why you are there. They may feel that you are there to harm them.

DISCUSSION QUESTIONS

WHEN YOU WERE IN THE ROLE OF RESIDENT:

Can you identify some of the feelings you experienced?

What thoughts ran through your head?

What did you feel like doing?

What did your caregiver do that was especially helpful?

Was there anything done that did not seem helpful?

WHEN YOU WERE IN THE ROLE OF CAREGIVER:

What feelings did you experience as you tried to understand the ne
of the resident?

What were you thinking?

What did you feel like doing?

IN YOUR ROLE AS OBSERVER:

What did you see communicated non-verbally?

What changes in the cargiver's voice did you note?

What changes in non-verbal communication did you observe as the scene was played out?

INSTRUCTIONS FOR ROLE PLAY PARTICIPANTS
GETTING NEEDS MET EXERCISE

OBSERVER

Your role is to observe the communication between the CNA and the resident. Note the facial expressions, body language, use of touch, tone of voice. Remember, you are to observe both the resident and the CNA.

CNA

You have a heavy assignment today and are feeling quite rushed. You need to get this resident, Lou LaVine, up and ready for breakfast.

RESIDENT Situation A

You have the following needs that you must have met. You know that the CNA will be with you only a short while and you must quickly communicate your needs to her. You are unable to speak.

Need #1 You have wet the bed.
Need #2 You don't want to get up.
Need #3 You are very anxious about your son's visit today.

RESIDENT Situation B

You have the following needs that you must have met. You know that the CNA will be with you only a short while and you must quickly communicate your needs to her. You cannot speak.

Need #1 You just learned that your old pet cat died.
Need #2 You have to go to the bathroom.
Need #3 You think someone crawled in your bed last night and you want to let someone know.

Note: These roles can be copied, cut, and attached to index cards.

RESIDENT Situation C

You have the following needs that you must have met. You know that the CNA will be with you only a short while and you must quickly communicate your needs to her. You cannot speak.

Need #1 You had fearful dreams last night and you need a hug.
Need #2 Your roomate took your sweater.
Need #3 You want something different for breakfast.

RESIDENT Situation D

You have the following needs that you must have met. You know that the CNA will be with you only a short while and you must quickly communicate your needs to her. You cannot speak.

Need #1 Last night, you remembered your childhood home. You want to go back there.
Need #2 You are certain that your roommate took your music box.
Need #3 This caregiver reminds you of your sister whom you dislike.

SECTION II

A Consideration of Difficult in "Understanding Difficult Behavior"

Factors Contributing to Problem Situations

This section explores some of the many factors that contribute to "difficult" behavior. The significance of self-esteem of the resident is the common thread woven throughout this section. Participants have the opportunity to choose their own assignment, exploring the reasons for their choice and how these reasons may influence their behavior toward the resident. Manipulative behavior is considered as a dynamic and defeating cycle that involves both resident and staff. Throughout this section participants are asked to consider the abilities that remain with the mentally impaired resident. This offers insight into behaviors that are easily misinterpreted. The section concludes with an opportunity to discuss aggressive and assaultive behaviors.

CONTENTS Page

Defining Difficult Behavior.....30
Handout.....31
Instructor's Note.....32
Understanding Manipulative Behavior.....33
Manipulative Cycle.....34
Handout.....35-36
Learning Experience.....37-38
Case Study.....39
Instructor's Guide.....40
Understanding Difficult Behavior
Backgound Information.....41
Handout.....42
Learning Experience.....43
Understanding the Mentally Impaired Resident.....44-46
Aggressive/Assaultive Behavior
Anticipating Problem Behavior Handout.....47-48
Assaultive Responses Handout.....49
Learning Experience.....50-51
Handout.....52-53
Worksheet.....54
Handout - Calming Techniques.....55-56

LEARNING EXPERIENCE

DEFINING DIFFICULT BEHAVIOR

OBJECTIVE: To recognize that we each define difficult behavior differently, based on our unique personalities and life experiences.

METHOD: Give each participant a copy of the "Choose Your Assignment" worksheet. Ask them to indicate, on the sheet, who would be their first, second, and third choice to care for if they could choose their assignment. Ask also that they take note of the thoughts that go through their minds as they make their choices. They may wish to jot a few notes about why they chose as they did. After they have done this, read them the additional information about each resident, advising them that it is acceptable to change their choices if they wish.

Encourage people to share what their preferences were. It is somewhat less threatening to begin by asking for a show of hands as to who chose Resident A, for example, as their number one choice, proceeding on through the list. After this is completed, ask if anyone would be willing to share some of the things they thought about as they made their choices.

DISCUSSION: Because of our unique personalities and variety of life experiences, we differ in how we respond to certain behaviors. For example, a participant once shared that all his life he had a difficult time with authority figures. He felt that the behavior c the demanding resident would be very difficult for him. Another participant was candid in sharing that she would have a very difficult time caring for a person who had killed someone while under the influence of alcohol. Another participant in that same group said she would prefer to care for this person as she felt compassion for what he had already been through.

Sometimes a resident reminds us of someone we once knew. Our feelings for that person, positive or negative, may influence the way we feel about the resident. Obviously, this may work in reverse as well. We may remind the resident of someone they once knew.

It is possible, even probable, that our feelings, positive or negative are conveyed in our behavior toward the person. It may be in the frequency of our visits to that room, what we say to the person, our tone of voice, our "body language", the quality of our touch, or one of a hundred other possible messages we might send. In recognizing and acknowledging the kinds of behavior that really "get to us", we take the first step toward understanding how to handle ourselves more effectively in difficult situations.

HANDOUT
CHOOSE YOUR ASSIGNMENT

Please rank order the following residents according to whom you would most like to care for (#1) to the person you would least like to care for (#3). As you do this, jot down some of the reasons why you chose as you did.

_____ Resident A: Mr. Jay is a 79 year old gentleman with moderate symptoms of dementia.

_____ Resident B: Mrs. Kay is a 74 year old woman with congestive heart failure and diabetes.

_____ Resident C: Mr. Ell is a 59 year old gentleman who suffered brain damage as a result of an automobile accident several years ago.

CHOOSING YOUR ASSIGNEMENT

INSTRUCTOR'S NOTE

This is the additional information about each resident. This should be read after participants have made their first choices.

Resident A: Mr. Jay frequently wanders away from the facility. He often makes his exit as visitors are leaving the building. He masturbates frequently, usually in the dining room, and touches female caregivers inappropriately.

Resident B: Ms. Kay, a retired RN, is very demanding, and highly critical of the care she receives. She frequently visits the administrator to complain about her care.

Resident C: Mr. Ell was the driver of a car that hit and killed a mother of four. He was legally drunk at the time. is frequently physically violent, striking out with no apparent warning or reason.

UNDERSTANDING
MANIPULATIVE BEHAVIOR

BACKGROUND INFORMATION:

"I don't think I can stand to take care of Mrs. Lane for even one more day. She is such a manipulator. The only way I can deal with her is to avoid her whenever I can."

This situation may sound familiar to those who work in long term care facilities. "Manipulative behavior" has been described as behavior aimed at getting one's needs met, usually without regard for the needs of others. The irony is that the stated needs are often not the real needs. People are often reluctant to ask for what they really need.

Who manipulates?

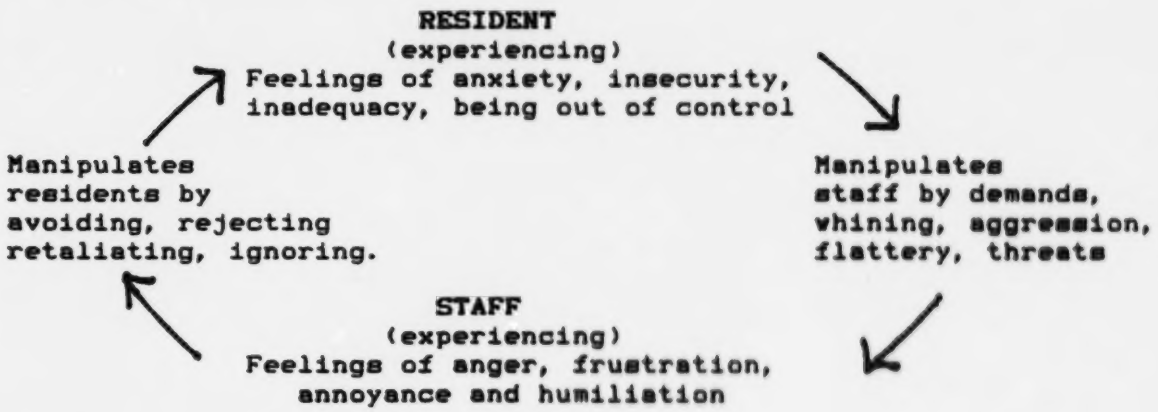
We all do, some of the time. We are more likely to use manipulative behavior when we feel it is the only way to get what we want. Manipulative behavior is seen as a problem when it becomes the primary means for getting needs met. The person being manipulated becomes annoyed and the person doing the manipulating loses the opportunity for direct, honest, and open interaction with those around him.

What are the real needs being expressed by manipulative behavior?

Some feel that the behavior springs from feelings of mistrust, insecurity, and lack of control over one's life. It is understandable that people who find themselves in a long term care situation might experience any or all of these feelings. Manipulative behavior becomes a means by which a person tries to regain some control over his environment.

The Manipulative Cycle

In the caregiving situation, it is easy for both caregiver and resident to get locked into a cycle of manipulation. The illustration below shows how the feelings of both resident and staff can keep the cycle going.


RESIDENT
(experiencing)
Feelings of anxiety, insecurity, inadequacy, being out of control
Manipulates staff by demands, whining, aggression, flattery, threats
STAFF
(experiencing)
Feelings of anger, frustration, annoyance and humiliation
Manipulates residents by avoiding, rejecting retaliating, ignoring.

Breaking the Cycle:

Staff can begin by:

1. Recognizing that the need for trust, security, and control are often at the root of manipulative behavior.

2. Separating the behavior from the person. Pigeon holing people as "manipulators" only helps distance ourselves from these people. It is more helpful to consider the person as an individual who uses manipulative behavior in an attempt to meet his needs.

3. Recognizing our personal responses to manipulative behavior. Do staff feel hurt, angry, humiliated, frustrated? Are those feelings acted out in behavior?

4. Considering where change is possible and working together, as a care team to affect change.

HANDOUT

MANIPULATIVE BEHAVIOR INTERVENTIONS

To consider appropriate responses to manipulative behavior, it is helpful to reflect on what need the person might be trying to meet and respond with the most meaningful intervention.

Need for Trust:

Avoid the label of "manipulator". Observe situations and times when this behavior increases.

Anticipate the person's needs where possible and meet them before the behavior occurs (i.e., a friendly, unscheduled visit at the beginning of your shift to say hello and ask about any special needs they might have).

Make even brief encounters meaningful. Sit down, use eye contact, and convey, non-verbally, that you are with them.

Need for Security:

Be consistent. Use the team approach so that each team member is giving the **same message.**

Set limits when necessary, again with a united front.

Communicate expectations clearly. In some situations, written agreements between staff and resident are helpful.

Ask for relief when you need it. Your distress is easily conveyed to the resident, thereby increasing his insecurity.

Need for Control:

Involve the resident in planning his care whenever possible. Even the resident who lives with many limitations can make some decisions regarding care.

Present the problem situation and seek the resident's input in how to solve it.

Offer choice where choice is possible.

Assist the resident in recognizing what they do well or what positive qualities they have. Create opportunities for recognition of these skills or qualities.

Above all, **work as a team.** The care plan should be updated frequently to reflect workable approaches. Each staff person shou.. have the opportunity to contribute to the plan. If something works, share it so that all may benefit. Communicate openly with one another.

Manipulative behavior benefits no one. A thoughtful and caring team approach toward meeting the unstated needs behind most manipulative behavior can benefit those who work and those who live in residential care facilities.

MANIPULATIVE BEHAVIOR
LEARNING EXPERIENCE

OBJECTIVES:

To apply manipulative behavior theory to specific situations.

To identify inappropriate staff responses to this behavior.

To discuss therapeutic responses to manipulative behavior.

METHOD:

The following case is designed to generate discussion about responding to manipulative behavior by a resident. Though the resident may act inappropriately, it is the responsibility of the staff to break, and not perpetuate, the manipulation cycle.

Ask participants to read the situation. The following questions should be available, either as a handout or printed on newsprint visible to all:

Who acted inappropriately in this situation?

What do you think the resident might be feeling?

What do you think the staff might be feeling?

What message was communicated to the resident?

Could this situation have been avoided? How? When?

How do you feel the outcome affected the self-esteem of the resident? Of the staff?

How do you think each will feel when they meet again? Can or should anything be done at this point?

Request that participants use these questions as a guide to the discussion. One person should note the comments of the group. If there is more than one group, have each group report back to the larger group.

DISCUSSION:

The following points should be included in the discussion:

*Many conflicts between resident and staff begin with the initial approach of the staff person.

*It is crucial that staff understand that the behavior they encounter with residents is rarely directed at them personally.

* In the caregiver role, it is their responsibility to respond in a way that is in the resident's best interest using respectful communication. (See handout with Manipulative Behavior)

* It is often appropriate to respond to the feelings behind the behavior rather than the behavior itself.

* If limits must be set on resident behavior, the message should be consistent from all staff.

*Staff need to attend to their own feelings in a healthy way.

Note: Additional discussion material can be found in the Instructor's Guide (p.40) to this experience.

CASE STUDY
MANIPULATIVE BEHAVIOR

Carolyn Seamans had been both an intensive care and public health nurse before retiring at age 62. She lost her husband six years after her retirement and had lived alone for seven years when health problems forced her to move to Sunny Hill Nursing Home. She is now 75 years of age. The staff at Sunny Hill consider Mrs. Seamans "a difficult and demanding" resident. Some of the caregivers jokingly refer to her as "Demon Seamons". The tensions that have developed between the resident and staff are evidenced by the following interaction:

It is 9:30 a.m. Staff are busy with morning routines.

Bev. (CNA): Mrs. Seamans light is on again. I can't believe it, she never stops.

Jim (CNA): When we were picking up trays she wouldn't let us have hers. She's probably ready now.

Bev.: Hey Chris, would you take her this time?

Chris (LPN): (Smilingly) Thanks, but no thanks. This is your day to develop character. (Group laughs)

Bev.: (Enters room) Yes Carolyn, what is it?

Mrs. Seamons: (In chair with tray in front of her) I asked you when you were in here before to open the blinds for me, (lying) and you said you would. Do you think you could do it this time? (Raising voice)

Bev.: (Irritated) I'm sorry but it wasn't me you asked. (Quickly opening blinds) I'll take your tray now, the kitchen wants them.

Mrs. Seamons: (Grabbing tray as Bev takes it) No, I'm not finished with my fruit yet.

Bev.: Now that's just enough (pulling tray away and putting fruit dish on table, walks toward door).

Mrs. Seamons: (angry) You wouldn't have lasted long when I was a nurse.

Bev.: (Sighing) Yes Carolyn, that's right.

NOTE: It is recommended that the discussion questions for this exercise be handed out with the case study. Have small groups consider the material before discussing with the group at large.

INSTRUCTOR'S GUIDE
CASE STUDY

1. **Do you see any manipulative behavior here? How was this being done? By the resident? By the staff?**

Discussion

Actually both staff and resident were manipulating each other. The resident by being untruthful and intimidating staff, "I asked you to do that when you were in here before..." And the staff by curt responses and avoidence. One study on aggressive behavior found that, "Aggressive patients were virtually isolated from normal human interactions. They were not visited by staff except for the "bed and body care" (Meddaugh, 1991). It's important to remember that regardless of who acts inappropriately, it is always the responsibility of the professional to respond in a way that is in the residents best interest, regardless of personal feelings.

2. **In what ways do you think that staff attitudes may be perpetuating the problems?**

Discussion

By inappropriate joking and "nicknaming", the staff are supporting a label that Mrs. Seamans is a "Difficult Resident". That label has become a barrier that makes it virtually impossible for staff to really "listen" to her.

3. **What need do you think this resident is trying to meet through her behavior?**

Discussion

Because of her background as a caregiver its easy to see how being institutionalized and cared for by others could be extremely difficult for her. We can understand how being included in meaningful interactions and having more control and choices would contribute to her self concept. When resident and staff become locked in a cycle of manipulation, the very things that would tend to be therapeutic are often the things that are withheld.

Other Discussion Questions

4. **What might Mrs. Seamans be learning about herself from the verbal and non-verbal messages staff are sending her?**

5. **If you were Bev. how would you have responded to Mrs. Seamans?**

6. **What changes would you implement to resolve this problem?**

UNDERSTANDING DIFFICULT BEHAVIOR

BEHAVIORAL PATTERNS IN LONG TERM CARE ENVIRONMENTS

Though taken out of context from a comprehensive workshop, the following handout illustrates a principle of understanding difficult behavior that is essential to problem solving. The behavior that is acted out is a symptom of a problem, not the problem itself. Trying to modify a symptom without understanding the actual problem, can lead to frustration for both staff and resident alike. The process of investigating the possible causes can be challenging and may take time, but success can yield long term benefits that will enhance resident care and staff satisfaction.

As the handout indicates, there can be multiple causes for a specific behavior. Because it is behavior that is being acted out, it is often our inclination to attribute it to a cognitive or psychological cause, or perhaps to old age. As the associated diagnosis demonstrate, the cause of behavioral symptoms can, and often is, a medical problem, a sensory impairment, or an effect of medication.

While this is not a comprehensive list of behaviors staff encounter, it does serve as a model for considering the possible causes for any behavior. It is offered here for that purpose.

HANDOUT
BEHAVIORAL PATTERNS IN LONG-TERM CARE ENVIRONMENTS

COMMON BEHAVIORAL PROBLEMS:

Wandering
- purposeful
- non-purposeful

Associated Diagnoses
- dementia
- adjustment disorder with disturbance of conduct
- medication-induced restlessness
- schizophrenia

Agitation
- verbal (yelling, screaming)
- physical (hand-clapping, constant motion)

Associated Diagnoses
- acute confusional state (delirium: all causes, including common medical problems such as hypoxia secondary to CHF, pneumonia; UTI's etc.)
- chronic confusional state: dementia, infection, neoplasm, etc.
- bipolar disorder, manic phase
- depression, agitated type
- anxiety disorders
- hearing loss

Aggression
- verbal (threatening, swearing)
- physical (kicking, biting, hitting)

Associated Diagnoses
- paranoia
- anxiety
- sensory loss, esp. hearing
- any medical condition leading to a delirium
- adjustment disorder with disturbance of conduct
- bipolar disorder, manic phase

Confusion
- reversible
- irreversible

Associated Diagnoses
- delirium (acute confusional state)
- depression
- dementia, Alz. type (DAT)
- sensory loss
- any medical condition leading to a delirium

Withdraw/Non-communication
- inactivity, isolation, non-verbal

Associated Diagnoses
- sensory impairment
- depression
- poststroke, other medical conditions

WEHRY (1992)

LEARNING EXPERIENCE

WHAT PRECIPITATES DIFFICULT BEHAVIOR

OBJECTIVE: To generate a discussion about the things that caregivers do, or do not do, that may trigger undesirable reactions from the resident.

METHOD

Participants should be situated around tables in small groups of 4-6. Groups can either use the bottom section of the worksheet found in the appendix or each table can be given a large sheet of 18 by 24" paper with a magic marker. Groups are given the task of developing orientation material for new employees who will be working with residents in your home. The groups are instructed as follows:

> Develop a list of things a new person should avoid doing, things that your experience has taught you will trigger a negative response from residents. Groups are instructed to divide material into the same categories outlined in the worksheet, (all residents) - (dementia) - (depression) - (paranoia) - (hallucinations & delusions), recording the special considerations for each, as lists are developed.

DISCUSSION

If you have used the worksheet, ask groups to share what they have recorded using offerings of the group as discussion material. If flip chart paper was used, collect and display sheets and discuss material with group.

NOTE: As you discuss the "what not to do material", ask participants to share things they have found to yield positive results when working with residents. (This might also be incorporated as a separate exercise.)

BACKGROUND INFORMATION

UNDERSTANDING THE MENTALLY IMPAIRED RESIDENT

Edelson and Lyons (1988)

The severely mentally impaired person suffers huge deficits in memory, comprehension, and verbal ability. Deficits of sight and hearing and a diminished energy level compound problems in communication. But, despite overwhelming losses and almost total dependency, universal human social and emotional needs are present. The following abilities remain operative within the person:

1. A fully intact emotional capacity. Fear, joy, excitement, pride, anxiety, sorrow, shame, sympathy are experienced, although their expression is not always understood.

2. An awareness of environment and a responsiveness to change occurring within it, even if events are not accurately or fully comprehended.

3. A sociability, showing capacity for concern for others that affirms the strength of the integration of social experience in the basic personality. Although the expression of concern and desire to help someone else when one can barely help oneself is not an unusual accompaniment of aging years, it is always beautiful to behold. When it is observed among the very dependent aged who, in addition, are severely impaired, it is very moving.

4. Social skills, which are retained even when there is tremendous loss in cognition. Practiced repeatedly throughout a lifetime, these social skills have been incorporated into behavior and are available for use in appropriate social situations. Such are the social graces contained in greetings and farewells, good wishes and congratulations, thank you's and expressions of appreciation. The immediate social response of an appropriate social greeting accompanied by a gracious social facade, can be deceptive and disguise the degree of mental impairment. But for the mentally impaired who have few words they can still retrieve for communication, the availability of these social remarks is a valuable asset. They are not merely manners: they indicate retained ability to react to other persons. The fact that the phrases are automatically spoken does not mean that they cannot convey deep feeling. These skills serve as a way of assisting the mentally impaired person to connect with others, and are a vital and main resource.

5. A way of communicating that, in the absence of verbal ability, has been developed in an individual and unique style. With severe speech limitation, resulting in jumbled words and incoherent sounds, communication nevertheless is established through body language, with eyes, posture, and gestures, in the emotional quality of the voice, in the feelings with which words are spoken.

6. An ability to make logical connections, which may not be readily apparent when the person's behavior seems irrational. Given the tendency to misconstrue the environment, to misinterpret messages, what seems an illogical or irrelevant action can well be quite logically connected to the impaired person's perception. The impaired person's environment is, after all, as puzzling to him as his seemingly irrational behavior is to us. Logical conclusions may be drawn on the basis of faulty perceptions. In an arithmetic class, if you copy down incorrectly the number the teacher has written on the board, it doesn't matter if you add, subtract, divide, or multiply the figures accurately, you will not get the correct answer.

SEARCHING FOR THE MEANING IN BEHAVIOR

Care must be attuned to and make a salutary connection with what the individual is experiencing. Behavior that may appear irrational and unreasoning can be understood only when we begin the difficult search for its meaning. When the individual cannot convey verbally what he is experiencing, our means of understanding is through paying attention to his behavior. **Behavior does have meaning. It serves a purpose for the individual.** The mentally impaired, because they cannot rely on their cognitive ability, tend to rely on their feelings to interpret their world and act accordingly. Since few can ask or explain in words, staff have to learn from the residents' actions what they need and want and interpret meaning in the language of their behavior--in the tears, screams, and scratching and even the repetitive sounds that signal comfort or distress. Establishing communication requires staff to reach out for understanding and relationship mainly at an emotional rather than cognitive level. It is very important not to dismiss seemingly irrational behavior as reflective only of deficits. Even if the person's repetitive behavior has a large organic component, it must not be interpreted as meaningless because it is one of the few remaining vehicles for the expression of the person. The pounding on the table, the pulling and pacing, if carefully observed, will change in intensity or frequency with the person's feeling of comfort or stress.

SEARCH FOR ABILITY

Just as it is important not to dismiss behavior as irrational, so it is important not to regard the resident as unable to do anything for himself in self-care because he does not initiate action. Because impaired persons may no longer be performing some ordinary details of daily living, like blowing their noses, eating with utensils, putting on stockings or shoes, taking out dentures, rinsing their mouths, doesn't mean they are incapable of these acts. In the face of their huge deficits in memory and comprehension, it may mean ony that each time they need help in getting started, or instruction in what to do and when. Being able to participate in self-care, even though the "start up" must be constantly supplied, is important for the retention of personhood, which is the ultimate objective of psychosocial care.

The potential ability to participate in self-care may be hidden by depression, by frustration, or by care that takes the easy way ou' misreading non-performance for inability and therefore having no expectation of the resident other than as a recipient of care. Acceptance of the status quo in an impaired resident's functioning does not accord respect or dignity. It conveys an attitude, "He's like that," that dismisses the person because of the symptoms of his condition rather than understanding the nature of mental impairment. The staff upon whom the resident is most dependent must have respect, in its fullest sense, for the person they serve, so they can visualize the potential ability beyond the evident disability.

SOURCE:

Edelson, Jacqueline Singer and Lyons, Walter H.,
Institutional Care of The Mentally Impaired Elderly,
Van Nostrand Reinhold Company Inc., New York, 1988.

•Instructor's Note:

This background information is presented as it appears in the above referenced book. The sensitivity with which the material is presented is essential to one's understanding of the person who struggles with a cognitive impairment. We highly recommend that each particpant have the opportunity to review this background information. The book would be a useful additional to the facility library.

HANDOUT

ANTICIPATING PROBLEM BEHAVIOR

What Do Staff Need to Know?

* History of the Residents Personality

  This helps staff to determine if current behavior is consistent with a life pattern. If not, other reasons for the behavior must be considered.

* Personal History of the Resident

  Information about family, home, and occupation will help staff in communicating in a more meaningful way. Staff will also have a clearer understanding of how living in a long term care situation affects a persons' sense of self.

* Experience of Other Caregivers with the Resident

  It is important to learn the likes and dislikes of the resident and to communicate this to other caregivers, making the caregiving experience easier for all. If there have been past incidences of behavior problems, new staff should be told what precipitates the behavior and how to intervene appropriately. Avoid using labels to describe people. Describing the behavior that you saw and heard is far more useful.

* Sensory Impairment

  Vision and hearing loss can affect a resident's behavior. Poor vision may deny them pleasures and hobbies they once enjoyed. They may be startled if you touch them without warning - even to the point of striking out at you. Loss of hearing can have profound effect on behavior - withdrawal from social activity, isolation, suspiciousness, loss of interest, even depression can be related to hearing loss.

* Cognitive Impairment

  Behavior will be affected according to the degree of impairment. Generally, a lessened ability to tolerate change, new people, new tasks, new situations accompanies cognitive impairment. The importance of routine, familiarity, a non-threatening atmosphere, gentle communication cannot be underestimated.

* Immobility

  The ultimate physical dependency limits personal choice and control unless caregivers are especially sensitive to their importance.

Of course, many of the residents you care for are influenced by several of these factors. The more a caregiver knows about an individual, the more prepared he or she is to provide personalized care in an atmosphere that provides optimum security, caring, and control to the resident.

HANDOUT

SITUATIONS WITH THE POTENTIAL FOR AROUSING ASSAULTIVE RESPONSES

1. Threats to self-esteem or self-image (that is, that require a patient to behave in an uncharacteristic or uncomfortable way) lack of choices or empathy; ... not being listened to.

2. Reminders of unpleasant past experiences.

3. Stimulus extremes (environmental and verbal).

4. New people or things in the environment (the lack of stability and routine for the AD patient.)

5. Misperception of changes (illusions).

6. Pressure to remember.

7. Direct confrontation.

Burnside (1988)

AGGRESSIVE/ASSAULTIVE BEHAVIOR
LEARNING EXPERIENCE

OBJECTIVES:

To use specific problem solving strategies to understand aggressive or assaultive incidents.

To assist caregivers in developing a plan of care to anticipate and meet some of the needs of the potentially aggressive or assaultive resident.

BACKGROUND INFORMATION:

This experience is based on several of the theories discussed by Boettcher (1983). It involves a problem solving approach we know as the nursing process. The elements include the gathering of information or data, assessment of the data, formulating a plan of care, implementing and evaluating the plan. The process is used to understand why aggressive or assaultive behavior is sometimes used by people when their basic human needs are left unmet. Emphasis is on preventing the frustration level of residents from reaching the point of violence.

Boettcher describes the following sequence of events as potentially leading to a violent reaction:

1. An alteration of a biopsychosocial need is experienced. (These needs are indicated on the handout included.)

2. A threat is posed to the self-esteem.

3. A state of arousal occurs.

4. Severe anxiety emerges.

5. Feelings of helplessness and entrapment arise.

6. The person is impelled to reduce anxiety and overcome these feelings.

7. The person resorts to behaviors which have successfully given mastery and control in the past over intense feelings of anxiety, helplessness, and entrapment.

The author maintains that each individual learns a way of coping with these uncomfortable feelings. The dominant learned response is the one that will be used when needs are not met. Some respond by constructive assertive behavior, some by withdrawing to reflect on the situation. These responses generally occur after the state of arousal occurs. (#2 in the sequence) and serve to reduce anxiety that, unresolved, would continue the process.

Some people attempt to deal with anxiety by destructive withdrawal which can lead to depression. The people we are discussing today, however, deal with anxiety with aggression or violence. This may be the learned method of dealing with frustration. It is also possible that they have an organic or functional problem, a neurochemical imbalance, or are drug intoxicated. Under these conditions, people are less able to tolerate need deficits or have intensified needs that extend beyond the usual norms.

METHOD:

This experience is most useful when discussing specific aggressive incidents of a particular resident. The "needs" model provides a framework to examine the behavior. Ask participants to share their objective observations of the resident as well as statements made by the resident. After information is noted, ask that the group devise strategies that could help meet the stated and unstated needs of the resident to decrease anxiety. It is equally important to have the group determine how they will share these strategies so that they might become part of the resident's care plan.

HANDOUT

ASSAULTIVE INCIDENT ASSESSMENT TOOL

This handout expands upon the Human Needs learning experience in Section 1. It may be used as a guide to discussing specific aggressive behaviors to determine possible contributing factors.

NEEDS:

TERRITORIALITY

Refers to the need for a comfortable space, freedom from crowding, privacy, freedom from unwanted physical intrusion.

i.e. Resident shoved nurse when she opened curtain around the bed.

One resident struck another who sat is his favorite chair.

COMMUNICATION

Refers to the need to be able to talk to another person (a doctor, lawyer, nurse, an aid, another resident, or a friend)

i.e. Resident struck an aid when told he could not see the doctor for two more hours.

Resident hit an attendant when he learned his wife refused t. talk to him on the phone.

SELF-ESTEEM

A need for respect from others - residents, staff, family, etc. Freedom from insults, shaming by others, stigma, humiliation.

i.e. Resident punched another resident after she called her a "stupid idiot".

Resident kicked a staff member when the latter teased her about her hairstyle.

SAFETY AND SECURITY

Refers to the need to protect self from harm and physical injury.

i.e., Resident struck another resident after the former hit her.

Resident struck another resident who threatened to get her later.

AUTONOMY

Refers to the need to make own decisions, have control over one's life.

i.e. Resident struck staff member when told he was not permitted to leave the building.

Resident struck nurse when told to put out her bedroom light and go to bed.

OWN TIME

Refers to the need to be able to move at one's own pace, not to be rushed or hurried by others.

i.e. Resident pulled caregiver's hair when told to hurry on to the dining room.

Resident grabbed an attendant when told that smoking time was over.

PERSONAL IDENTITY

Refers to the need to retain personal items and identifying material.

i.e. Resident tore the nurse's clothing when her own clothes were taken from her.

COMFORT

Refers to the need to be free from physical or emotional pain or hunger or thirst, excessive heat or cold.

i.e. Resident punched the I.V. therpist when the latter had difficulty inserting the needle.

Resident bit the nurse when told that breakfast was postponed until after lab tests.

COGNITIVE UNDERSTANDING

Refers to the need to be aware of surroundings, to be free from confusion about what is happening.

i.e. Resident, while hallucinating, threw a chair at the nurse.

Resident struck an aide while apparently intoxicated or high on drugs.

SOURCE: Boettcher. (1983)

*The term "resident" is substituted for "patient".

ASSAULTIVE/AGGRESSIVE BEHAVIOR

WORKSHEET

Consider Specific Resident Behavior

Describe the Behavior You Observe	What Might the Resident Be Communicating	What Are Possible Helping Strategies

HANDOUT
NON-VERBAL AND VERBAL CALMING TECHNIQUES

Not all disruptive situations can be resolved with calming techniques. However, the way in which a caregiver approaches a disturbed resident can often influence the outcome of the episode. Following are a few non-verbal and verbal calming techniques that may be useful in particular situations.

NON-VERBAL TECHNIQUES:

- Establish eye contact, at the resident's level if possible. This conveys your attention and concern. Keep in mind, however, that many older people have vision impairments and may not know who you are.

- Maintain a non-aggressive body posture. Avoid towering over the resident. If you must approach the person, do so calmly and with confidence. Avoid gesturing with your hands and arms. A "palm's up" approach is perceived as less threatening than palm's down.

- Maintain a pleasant facial expression, avoid scowling, frowning, etc.

- Position yourself near, but not blocking an exit. Avoid sudden movements toward the person as this can be easily misinterpreted and heighten anxiety. Stay with the person, but do not touch them without permission.

- Walk with the person if appropriate. Walking often helps release tension.

- Listen to the person. Allow them to vent their feelings, even if they do not make sense to you.

- Allow a cooling off time.

- Decrease the noise and activity in the environment. Move to a quiet area if possible.

VERBAL TECHNIQUES:

It is very important that your verbal and non-verbal messages are congruent. Nice words can be spoken in a harsh or sarcastic tone, thereby confusing the receiver of your message. When there is this kind of inconsistency, generally the non-verbal message will be believed.

- Monitor the tone of your voice. Often, when under stress, our voice becomes more shrill and thereby, harder to hear and more annoying to the listener.

- Avoid "why" questions. Instead, ask open ended questions such as "What's bothering you?"

- Give simple questions, slowly, and one at a time. Allow ample time for a response.

- If the situation allows, use distraction as a way of redirecting the moment's energy.

- Avoid asking the person to make decisions. This may be an overwhelming request in an anxiety producing situation.

- Never scold, berate, or in any way humiliate the person. Even the severely congitively or mentally impaired person understands those feelings and will be adversely affected.

SECTION III

A Consideration of the Understanding in "Understanding Difficult Behavior"

Communication

This section stresses the importance of excellence in communication in addressing and resolving problem behavior situations. This includes staff to staff communication as well as staff to resident. It begins with problem solving models that can be used to gather information about specific situations. There is a brief review of basic communication and helping skills, with specific suggestions for communicating with the mentally impaired elderly. The importance of knowing the resident and communicating what you know is a common theme in staff to staff intervention. Finally, the "helper's secrets" learning experience offers the opportunity for staff to discover how internal stress affects their personal well being, as well as the quality of care and understanding given the residents.

Contents — Page

Communication
- Background Information....58
- Helping Skills....59-61
- Learning Experience....62
- Worksheet....63
- Instructor's Guide....64
- Handout....65-66

Knowing the Resident
- Background Information....67-68
- Learning Experience....69
- Handout....70
- Autonomy Learning Experience....71
- Worksheet....72
- Instructor's Guide....73
- Assessment Guide....74
- Handout....75

Problem Solving
- Learning Experience....76
- Handout....77-79
- Worksheet....80

Caregivers
- Background Information....81
- Helpers Secrets....82
- Instructor's Notes....83
- Learning Experience....84-85
- Care for Caregiver Handout....86

COMMUNICATION

BACKGROUND INFORMATION:

The messages we send to one another are vitally important, especially those that indicate how one person perceives another. Even a healthy self-concept can be destroyed by a daily barrage of negative messages. The way other people view us becomes the mirror through which we see ourselves. Direct caregivers spend more time with residents than other members of the health care team. Therefore, the messages they transmit through daily interactions become a vital factor in the psychological and emotional health of the resident.

Messages can be sent both verbally, through the use of words, and non-verbally through body language. Research has indicated that as little as 7 to 30% of a face to face communication is sent through the words we say. The remainder of our interpretation of a message comes from the non-verbal component.

Since one of the essential ingredients of a relationship is trust any way that trust between a caregiver and a resident can be strengthened will enhance the relationship. Of the many things a caregiver can do to establish trust, the most significant is to actively listen to what the resident is saying. Active listening sends the message, both verbally and non-verbally, that the resident is being heard.

Practicing the following listening and helping skills will help the caregiver accomplish two essential goals:

By listening intently to the resident, they establish themselves as a real psychological presence for the individual.

By listening, they convey to the resident an active interest and concern about his or her welfare.

HELPING SKILLS

BACKGROUND INFORMATION:

Helping skills are those which are used to assist residents in expressing their feelings. They are listening skills which are used to open the door to expressions of feelings, thoughts, emotions and ideas.

The basic helping skills are ATTENDING, PARAPHRASING, CLARIFYING and PERCEPTION CHECKING. We use many of these skills daily. Each of them enchance our understanding of messages that we send and receive. As a caregiver, these skills are valuable and useful.

ATTENDING

Attending is a skill that includes eye contact, posture, gestures and non-verbal behaviors. Attending is a way of acknowledging the feelings, ideas and thoughts of a resident. It shows the residents that you are interested and concerned about their feelings. In understanding and using the skill of attending, you will be able to better focus on what the residents are communicating.

EYE CONTACT

Eye contact is a very important behavior when attending or listening to a person. The eyes are a way of making non-verbal contact with another person. Eye contact should be natural (not staring). It is important to be sincere, and not force eye contact. Consider the comfort of the person with whom you are communicating. Observe the facial expressions. Maintain a distance that is comfortable for both of you.

POSTURE

Posture is an attending behavior that shows the helper is listening and is interested. Posture should be relaxed and comfortable. Lean slightly towards the person. If you are both sitting turn your body toward the person you are listening to. If a resident approaches you and you are standing, find a place where you both can sit comfortably. If the resident is in bed, sit in a chair beside the bed where you can be seen and heard. Going for a walk with the resident may be relaxing for both of you. Walking can release tension and reduce anxiety. Perhaps sitting outside would be appropriate. Creating a quiet and relaxed environment is part of posture.

GESTURES

Gestures communicate, in a non-verbal way, our understanding of messages. Inappropriate use of gestures can confuse the resident. Examples of gestures are nodding or shaking of the head. Nodding can indicate agreement or understanding; shaking the head may indicate a NO in response to a question, disagreement, or perhaps "I am sorry".

Hands and how they are used give many messages. A fist may indicate anger or tension. The open hand may give the message of "I want to help". Hands are an indicator of how a person feels. We touch wit our hands to soothe, and to comfort. Folded hands may give the message "I am listening, or I am relaxed". A shaking finger is used to emphasize a point or perhaps to scold.

Ask yourself what hands mean as you observe others. Notice the gestures that others make. What may the non-verbal message be? Notice the hands of the resident. They tell many stories.

VERBAL BEHAVIOR

Our words should reflect what is being said by the resident and not change the subject. The words you use indicate that you understand what you hear. By keeping your words in tune with what you hear, you show that you are listening and understanding the correct meaning. "I see what you mean" can help residents to continue sharing their thoughts and feelings.

The tone of your voice is also important. Does it show calm and relaxed attention to the person you are listening to? Is it animated when you acknowledge what you hear, or is it flat? A flat tone of voice might indicate boredom or lack of interest. Is your tone of voice one that can be heard by someone with a hearing impairment? A lower tone is more easily understood.

PARAPHRASING

Paraphrasing helps the listener understand the meaning of what is being said. It is repeating to the resident what he/she has said, but in fewer words and without adding ideas of your own. This process is necessary in order to fully understand what you are hearing. When listening to another person, observe for feeling words and thoughts. While this skill at times may seem artificial, it is very helpful in demonstrating that you are concerned and want to understand.

PERCEPTION CHECKING

Perception is how we interpret what someone else says. It is a way of checking what you hear for accuracy. It is also a way of giving and receiving feedback. Residents may not be comfortable sharing feelings or may not be able to express them in words. If we comment "You seem to be very unhappy today" you are giving a person the opening they may need to share with you. It may be helpful to ask the resident to confirm that. "Are you feeling down or unhappy?" The resident then has the chance to acknowledge the perception that you have or correct it if it is not accurate.

CLARIFYING

Clarifying is a helping skill that clarifies vague statements. You may have to guess at what the message is or ask for more information. The words used may be confusing, or go in circles. For clarification, you may say, "I am confused, I don't understand. Please explain to me again what you said." It can help to restate what you heard. Notice the non-verbal reactions of the resident. A change in facial expression or body language may provide needed clues.

RECOGNIZING NON-VERBAL BEHAVIOR

LEARNING EXPERIENCE

OBJECTIVE:

To stress the importance of attending to non-verbal communication.

To discuss the importance of "validating" what you think you see.

METHOD:

Give each participant a copy of the worksheet and ask that they label each face with the feeling he or she thinks is being conveyed.

DISCUSSION:

This is a light hearted way to discuss the significance of one kind of non-verbal behavior - facial expression. Because there will be differences in interpretation of the faces, the point can be made that it is important to clarify with the individual what they are feeling.

It is important to:

1. Recognize that a feeling is being conveyed.
2. Clarify what that feeling is, thereby eliminating false assumption.

WORKSHEET

HOW WELL DO YOU RECOGNIZE NON-VERBAL LANGUAGE?

Match the faces to the description of feelings.

Miserable
Paranoid
Ecstatic
Arrogant
Suspicious
Frightened
Curious
Distasteful
Optimistic
Hungover
Disbelieving
Disappointed
Lovestruck
Withdrawn
Hurt
Lonely
Obstinate
Disapproving
Mischievious
Envious

INSTRUCTOR'S COPY

HOW WELL DO YOU RECOGNIZE NON-VERBAL BEHAVIOR?

Miserable
Paranoid
Ecstatic
Arrogant
Suspicious
Frightened
Curious
Distasteful
Optimistic
Hungover
Disbelieving
Disappointed
Lovestruck
Withdrawn
Hurt
Lonely
Obstinate
Interested
Disapproving
Mischievious
Envious

HANDOUT

COMMUNICATING WITH THE MENTALLY IMPAIRED OLDER PERSON

Communication can be very frustrating for the person who experiences memory loss, who is unable to find the right words to express his wants and needs, who cannot form complete thoughts, or who speaks with words that only have meaning to him. This frustration is felt by family members and staff as well.

While every situation is unique, the following suggestions may be helpful as you formulate the communication strategies that are most helpful with a particular individual.

1. Sensitize yourself to the distractions in the environment. If necessary, close the curtain around the bed, close the door, or move the person to a less disturbing area. Older people in general, and those with cognitive impairments in particular, have a difficult time concentrating when there are distractions around them.

2. Make sure the person can see you before you begin to speak. Call them by the name they prefer. Let them know who you are and what you are there for.

3. Speak slowly and clearly, keeping the tone of your voice low. A low pitch is easier for those with hearing impairments to hear. Also, when we are stressed, we often raise the tone of our voice signaling that we are upset. People with cognitive impairments are very sensitive to this and respond to tension with tension.

4. We communicate non-verbally in other ways. A stern expression, a frown, a less than gentle touch, a rigid body posture, all communicate tension to the person. This can be very upsetting and can trigger a negative response.

5. Take your time! A hurried manner often leads to frustration in both parties. The elder needs time to absorb information and directions. It is most helpful to proceed slowly, give only one message at a time, and look for a response before continuing.

6. Often, tasks must be broken down into simple steps so that the person may be successful. Remain sensitive to the feelings of frustration or embarrassment when a task cannot be completed. Give lots of encouragement and focus on the things that the person can still do well.

7. Sometimes, a communication impairment is so severe that the perr cannot speak at all or his words are unintelligible. The non-verbal communication of both persons takes on even more importance. Clues to the person's well being may come from facial expression, body posture and movement, and eye contact. You will send messages with your voice tone, the expression on your face, touch, gestures, and the very fact that you are validating this person's significance by spending time with them.

8. Sometimes, when the words spoken do not make sense to you, you can gain insight by carefully listening to the changes in the person's tone of voice, the speed and intensity of the sounds, and the daily patterning of these sounds. They are usually not as arbitrary as might first be assumed, but, rather change in response to the needs of the person.

9. Even when you cannot understand the content of a particular statement, you can respond to the feeling being expressed. Sometimes simply letting a person know that his feeling is acknowledged and respected can help.

10. Finally, whatever the purpose of a particular interaction, it is always essential that an attitude of respect is conveyed to the person. A respectful attitude from another person may be one of the few ways left for the cognitively impaired person to maintain a sense of self-esteem. This must be vigilently maintained.

KNOWING THE RESIDENT

BACKGROUND INFORMATION:

Throughout this manual, we have stressed the importance of caregivers knowing the people they care for as unique individuals, with varying interests and abilities. In presenting the Understanding Difficult Behavior Series at long term care facilities, we found that it is often the little every day care situations that provoke some of the most troublesome behavior among residents. This is especially true when the ability to communicate verbally is compromised. The irony is that often a particular caregiver has discovered a way to handle the situation effectively but has not passed this information on. A few actual situations serve as illustrations:

A resident, just bathed and dressed, sits on the edge of his bed, Usually a hearty eater, he has refused breakfast. He becomes more and more anxious, clutching at his T-shirt. He cannot tell anyone what is wrong, but it is becoming very clear that his agitation may soon progress to aggressive behavior. The CNA is just looking for the charge nurse to tell her Mr. J. is not cooperating. By chance, another CNA who knows Mr. J. walks by and seeing him, knows immediately what is wrong. She helps Mr. J. remove his T-shirt and explains to the other aide that he cannot tolerate these shirts around his neck. Apparently, another person's shirt was put in Mr. J's laundry by mistake. As soon as the shirt is removed, Mr. J. calms down and eats his breakfast.

Mrs. R. is not a favorite on the unit. Morning care always seems to turn into a battle of wills. She routinely refuses to cooperate with any part of her care. Those who are assigned to care for her try to get in and out of her room as quickly as possible. One caregiver has a very different perspective. She says she does not have a problem with Mrs. R's morning care. She has found, by trying several different approaches, that Mrs. R. enjoys a few moments of social visiting before proceeding with her care. She takes a few moments to sit down and coverse with Mrs. R. much as one might do with a friend. Then she asks her if she is ready to proceed. She has had no problem since she has been approching Mrs. R. in this manner.

Mrs. B. becomes very distressed during her morning bath. She is unable to assist in any way. Usually she had a bed bath in her room. During her bath, however, Mrs. B. becomes very agitated and weeps. One day, during an especially stressful bath, the CNA looked at what Mrs. B. saw when she was being bathed. She saw a large picture of Mrs. B's three grandchildren. They were looking back at her. With a look of new understanding, the aide turned the picture face down on the dresser. She looked back at Mrs. B. and saw the look of relief on her face. The bath proceeded smoothly from that point.

Too often, this valuable information is not passed along to other caregivers. If it is, it is done by "word of mouth", not always a very reliable method of communication. It is vitally important that care facilities develop a process through which important care information can be shared with other caregivers. The official nursing care plan may not be the most effective communication tool for the direct care provider.

Charlotte Eliopoulos suggests that CNA's may find it helpful to have important aspects of care written on index cards which they can carry in their pocket for easy reference throughout the day. The cards can be collected and redistributed at the beginning of shift to the next staff person. Direct care providers may have ideas about other ways to share information. Whatever the process, the goal is to get this important care giving information into the hands of those who need it most.

LEARNING EXPERIENCE
KNOWING THE RESIDENT

OBJECTIVE: To introduce a tool that can be used to communicate caregiving information.

To acknowledge the significance of the information that direct care providers bring to the care situation.

METHOD: Provide each participant with a copy of the accompanying handout. Ask that they choose a resident (more than one if the group is large) to discuss using the handout. They should each volunteer the information they have about the resident as it relates to the items on the handout. One person should be responsible for assembling the information on one sheet. Direct participants to be as specific as possible.

Example:

Instead of "needs help with bath" say, "Is able to wash face and arms."

Instead of "feeds self", say "feeds self but needs encouragement."

KNOWING THE RESIDENT
HANDOUT

Using the suggested outline, indicate those special things you know about this resident. Consider what would be helpful for caregivers to know. Be specific, i.e., help with bath.

Example of help with bath:
Prepare face cloth with soap and water. Put in residents right hand. Needs assistance with rest of bath.

Format to be used:

Residents Name:_____. Likes to be called:_____.
Room location: Room Number. Which bed.

Oral care:

Feeding:

Toileting:

Dressing:

Ability to move about:

Sensory losses or difficulties:

How can staff help compensate for these losses?

Speech difficulties:

Favorite things to do or wear:

Any special arrangement for personal items in room.

Is there a special location resident likes?

Any special relationships with other residents? What are they and with whom?

Are there any special circumstances or events that might upset the resident?

Feeding: self, with help. Likes/dislikes about food, arrangements of utensils. Location. What is resident able to do?

Sleep/rest:

Other special needs:

Special problems related to behavior.

What positive qualities does the resident have?

What opportunities are there for these qualities to be used?

LEARNING EXPERIENCE

AUTONOMY IN EVERYDAY LIFE

OBJECTIVE:

To illustrate the importance of effective communication between residents and caregivers.

BACKGROUND INFORMATION:

In a study conducted in several long term care facilities, a sample of 135 residents and 135 nursing aides completed a survey. They were asked to comment on choice and control over a number of topics related to daily life in the facilities. Residents were asked to rate each area according to the importance of choice and control to them. The caregivers were asked to rate each area according to how important they <u>believed</u> these areas were to the residents. Very interesting results occurred. (see results)

METHOD:

Give the list of topics to each participant and ask that they rank the topics according to how they <u>believe</u> residents in their facility would respond. On a flip chart, tabulate the results.

Next, pass out the "results" sheet and, with the group, compare the results. There are usually several discrepancies.

This can be the jump off point to discuss how people perceive situations differently based on their own beliefs, values, and life experience. Stress the importance of not making assumptions about what is important to another person. One of the pitfalls of being a caregiver is that we sometimes presume we know what others want and need.

Also, it is useful to point out that it is not always the big changes or losses that whittle at someone's self esteem, but the daily assaults on one's ability to choose.

WORKSHEET

TOPICS

TOPIC	RANK
Getting up in the morning	
Going to bed at night	
Food	
Money Issues	
Visitors	
Personal Care Issues	
Ability to leave the facility for a short time	
Activities	
Roommate issues	
Access to phones and mail, consultation with a physician and admission to hospitals	

INSTRUCTOR GUIDE

STUDY RESULTS

Importance of Control Over:

Resident Ranking		Staff Ranking
1	Leaving for a short time	3
2	Using phones, etc.	10
3	Roommates	5
4	Care routines	7
5	Activities	1
6	Food	4
7	Money	9
8	Getting up	6
9	Going to bed	8
10	Visitors	2

CAREGIVERS SELF-ASSESSMENT GUIDE

In the introduction to this manual, we mentioned that as important as it is for caregivers to understand the behavior of the people they care for, it is equally important for them to understand their own behavior, and its influence on the behavior of others. Ebersol (1988) has included an adapted version of a Nurses Self-Assessment Guide that was originally developed by C.O'Conner. This guide can be used as a counsciousness-raising exercise to examine caregiver ability to relate to residents, especially those challenged with organic dementias. The tool can be useful, not only for self-discovery, but as a way for facilities to assess educational needs and stress management needs of staff.

SELF-ASSESSMENT GUIDE

Do I avoid a client unless I have a specific task?
Do I talk to client or do I carry out procedures in silence?
Do I address the client by name?
Do I proceed with care in spite of the client's objection?
Do I feed the client mechanically and hurry to finish?
Do I speak loudly even when there is not a hearing problem?
Do I routinely assign this person to someone else if possible?
Do I recognize this client as having any strengths?
Do I consider ways to help the client understand the situation?
Do I instruct the client as I would with any other with the hope th.. they will understand?
How do I feel about this client and his or her situation?
Do I feel the family has abandoned the client, and, if so, why should I care?
Do I feel the family is unreasonable in their demands to assuage their guilt?
Do I ignore the family and their involvement with the client?
Do I feel the family is not managing decisions related to the client in a realistic manner?

Ebersol. (1988)
Adaptation from O'Conner (1985)

HANDOUT

HOW RESIDENTS WANT STAFF TO ACT

- Move and speak slowly, wait for responses, and do not "grab or yell."
- Give a specific time when you will return to continue care; keep to this time.
- Promote resident decision making.
- Spend time talking and listening to the resident.
- Do not "talk down" or treat the older adult as if he were a child.
- Allow "mistakes" to occur without reminding the older adult.

Brooke (1989)

PROBLEM SOLVING MODEL
LEARNING EXPERIENCE

OBJECTIVE: To discuss a problem situation using a specific model of information gathering.

BACKGROUND:

While caregivers might wish that there was one magic strategy that would always work in difficult behavior situations, they know that each person and each situation is unique and demands an individual approach. What would be helpful is to have a model with which a problem care situation could be analyzed. This exercise expands upon a model developed by the Residential Health Care Facility Training Project.* This model presumes that there are three dimensions that need to be explored in a problem situation:

What is going on with the resident?

How are staff influencing the situation?

What environmental factors need to be considered?

We add a fourth element: What are some of the strengths of this resident?

The process is one of information gathering so that there can be a better understanding of the situation and, subsequently, a more holistic approach to the plan of care.

METHOD:

Prior to the inservice, particpants are asked to think about a resident care situation that they would like to discuss using the information gathering model. It is preferable that it be one with which many people are familiar so that there can be a richer perspective on the situation. Each participant should be given the handout PROBLEM SOLVING HANDOUT and WORKSHEET and instructed to work in small groups to gather information. In general, groups of five or six encourage the participation of each individual. Specific instructions for the facilitator are noted on the TRAINER'S GUIDE sheet. After the small groups have completed their discussions, the larger group should be reconvened and the information from each group compiled on sheets of newsprint, along with the groups' recommendations for possible change.

DOBROF (1982)

PROBLEM SOLVING HANDOUT

This problem solving method is useful for those situations where the resident's behavior is annoying or upsetting but not an immediate threat to himself or others. It requires some time and an open mind to try to determine what is being communicated by the disturbing behavior and what are the possibilities for change. This model is offered as a guide to assist you in recalling information that might be helpful in putting the pieces of this behavior puzzle together.

RESIDENT:

INFORMATION GATHERING:

Does this person have a mental or physical illness that might be contributing to the problem?

Am I knowledgeable about the illness(es) this person has? Do I understand how they might affect behavior and the ability to communicate needs?

What do I know about this person's previous personality? What has the family shared with staff that might be helpful in understanding this behavior?

POSSIBILITIES FOR CHANGE:

Does this resident need to be evaluated or re-evaluated because of a change in his condition?

Are all who care for him familiar with the treatment plan?

What need is being met by this behavior?

Is there another, more therapeutic way, to meet this need?

STAFF:

INFORMATION:

Is my (our) attitude or feelings about this person affecting the way I behave toward him?

Has this person been "labeled" in our facility? Is this affecting the way we approach this resident?

Am I aware of my non-verbal behavior around this person? Are my verbal and non-verbal messages congruent?

Do I set unrealistic expectations about what I should be able to achieve with this resident?

How important is it for me or "staff" to win in these situations?

Is there any person on staff that has a good rapport with this person? What have they found to be a helpful approach?

How do we communicate this helpful information so it is available to all caregivers?

POSSIBILITIES FOR CHANGE:

What can I change in my approach to this resident that can help me be more effective?

How can we better support one another when we have a difficult assignment that might include this resident?

Are there early warning signs that trouble is brewing with this person? Do I know what these are and how to handle them? How is this information shared?

Have I found effective ways to deal with my own stress? What have I found helpful?

How can we help each other with stress management?

Can I feel comfortable asking others to observe my non-verbal communication with this person so I may make necessary changes?

Whom can I ask for additional information about this person's physical or mental illness?

ENVIRONMENT:

INFORMATION:

Is this person reacting to something in the situation or in the environment?

Where, in the home, is the person most troubled, least troubled?

Is there a time of day during which the problem becomes worse?

Do visitors have any effect on the situation?

Is the problem related to specific activities....bathing, whirlpool, eating, social activities, etc.

Is it possible that the resident is misperceiving the environment?

POSSIBILITIES FOR CHANGE:

Is there something in the situation or environment that can be changed?

Is there too little or too much activity or stimulation?

Can procedures be done during a different time of the day?

Do you feel staffing patterns influence the behavior of this client? What would your recommendations be?

RESIDENT STRENGTHS:

INFORMATION

What are some of the positive qualities of this person?

What strengths remain?

What do you enjoy about this person?

What can staff do to reinforce and maintain the abilities that this resident retains?

PROBLEM SOLVING WORKSHEET

Resident Intitials: _____

Resident:

Information: _____ .

. _____ .

. _____ .

Possibilities for Change: _____ .

. _____ .

. _____ .

Staff:

Information: _____ .

. _____ .

. _____ .

Possibilities for Change: _____ .

. _____

. _____ .

Environment:

Information: _____ .

. _____ .

. _____ .

Possibilities for Change: _____ .

. _____ .

. _____ .

Resident Strengths:

Information: _____ .

. _____ .

Possibilities for Reinforcement: _____ .

. _____

CARING FOR THE CAREGIVER

BACKGROUND INFORMATION:

Several years ago, as part of the GERO program, we had the opportunity to conduct workshops on caregiver burnout in several of the residential and nursing care facilities involved in the training programs. The staff in these facilities cared for some of the most challenging people in terms of "difficult behavior".

We approached these sessions with the preconceived notion that these very ill and difficult to care for residents would be the primary cause of caregiver burnout in the long term care setting. We could not have been more mistaken.

We asked caregivers the following question: "What, other than higher wages, would improve your work situation?" The answer was not easier to care for residents, a newer facility, or better equipment. The overwhelming first response was "recognition and appreciation by administration for the work that we do". In other words, a little more care for the caregiver. When asked "What keeps you coming back?", the universal response was the residents - even the "difficult" ones.

We ask a great deal from the direct care staff in long term care. We ask they be efficient, accountable, quick, kind, caring, concerned, understanding, and respectful of the needs of others. For this, they are paid a wage and told that this is all they should expect. This is not enough.

Every person in the caregiving field wants and <u>needs</u> to feel cared about and recognized for the outstanding contribution they make to the quality of life of the residents in the home.

We developed this final experience to provide staff the opportunity to discuss stressors they face everyday and to share ways they cope and strengthen themselves. Emphasis is placed on strategies that can help individually, as well as those that can enhance a stronger sense of team.

HELPER'S SECRETS

BACKGROUND INFORMATION:

There are many causes of caregiver stress in the long term care setting. One of the less frequently discussed stressors are the "secrets" that caregivers hold within their hearts and minds. Larson (1987) conducted a study of 495 nurses attending professional conferences. They were asked to share, anonymously, some "secret" behaviors, thoughts, and feelings related to their work by writing them on uniform sheets of paper. The responses were analyzed using eight coding categories reflecting the major themes and issues in the helper's disclosures. The categories are indicated on the facilitator notes for this exercise.

Larson maintains that the origins of these secrets lie in four areas: a tendency to self-blame by those approaching burn-out; unrealistic self-expectations; discrepancies between real and ideal images of self as helper (i.e. the image of helper as always putting others needs first); and, the belief that no one else feels this way. It is further postulated that by keeping these "secrets", the process of healing communication is absent. These secrets can "increase the likelihood that these difficult experiences will result in long term stress related illnesses and burn-out".

According to Larson, one of the best antidotes to these secrets is self-revelation to the appropriate people in the appropriate manne Larson feels this is most helpful when done with co-workers or oth in the same line of work who can have "instant empathy". In a trusting and supportive atmosphere, staff support meetings can be very helpful. Through sharing, people find they are not alone in their thoughts. Unrealistic expectations can be tempered, feelings shared and worked through, and the tendency toward self-blame extinguished-replaced by healthier coping and problem solving skills.

Source: Larson, (1987)

HELPER'S SECRETS

INSTRUCTOR'S NOTES:

The secrets identified by the nurses in Larson's survey included the following:

I Feel Inadequate ----- 20% of the secrets were assigned to this category. Feelings of self doubt, that one is not bright enough or experienced enough for the job at hand. These fears are especially significant when human lives are involved as the significance of "errors" is magnified.

One Way Giving: What About Me? ----- In the helping professions, the focus of concern is on the recipient of care. Yet, caregivers often desire nurturance and care themselves. These feelings, when held secret, are often accompanied by self-criticism at not asserting one's needs and getting them met.

Too Many Demands ----- 5% of the disclosures were on the theme of difficult feelings associated with emotional and physical demands at work and at home. Feelings of not wanting to fail or feelings of resentment at being manipulated.

I'm Angry ----- 20% indicated feelings of anger at co-workers, administrators, doctors, families, and patients. The anger was at not being able to change the system, at uncaring or incompetent staff, or at patients who won't cooperate.

I'm in Over My Head ----- 11% indicated feelings of being over involved in work and care. Frightening feelings of not being able to let go of the hurt felt for patients and their families.

Emotional and Physical Distancing ----- This was the largest response catagory. 22% said they were concerned about distancing themselves from their patients, probably in an effort to avoid over involvement. These efforts often led to feelings of guilt. The stress avoidance guilt theme was a common one.

Wishing For A Patient's Death ----- When patients are enduring suffering with no hope of recovery or quality time, feelings of sympathetic distress, guilt, and anger can surface. Feeling guilty about feeling grateful that someone died is a common theme.

I Want Out ----- 3% of the secrets reflected a desire to get out of the field. Feeling overwhelmed with the life and death aspect of the work.

The author of this article, and researchers in other areas, are finding significant evidence that failure to express thoughts or feelings about these events may cause as much psychological and physiological stress as the events that triggered these feelings. When the process of healing communication is inhibited, obsessive thinking about the events increase the likelihood that these experiences will result in long term stress related illnesses and burnout.

HELPER'S SECRETS

OBJECTIVES:

To provide an opportunity for caregivers to discuss feelings related to work stressors.

To share strategies for coping with these feelings.

METHOD:

This exercise can only succeed if the participants feel confident that they are in a safe and non-threatening environment. The atmosphere must be supportive and there must be agreement that what is shared in the group stays in the group. It is also important to stress that it is not the point of the experience to judge feelings as good or bad. Feelings are just that - feelings; how one acts upon feelings is the central issue. Our feelings can have a positive or negative influence on how we do our work. Discussing some of the "secret" feelings that may be affecting us in a negative way is the first step toward working on solutions.

The facilitator might begin with a general discussion of staff stress in the long term care facility. It is important to distinguish between external stressors - the environment, co-workers, residents, administration, etc. and internal stressors - our negative feelings, thinking, and self-talk, etc.. Indicate that the focus of today's discussion will be internal or self-imposed stress. The facilitator may wish to point out that discussion of these stressors can be useful because they point to areas that demand greater attention and change. Kept inside, they erode from within.

Distribute plain index cards to the participants. Ask that they write on the card one of the difficult thoughts or feelings they have that they might not be willing to share aloud. If some have difficulty thinking of what to write, you might talk a little about the issues expressed by the nurses in the article. After several minutes, collect the cards. Shuffle to assure anonymity. This is the time to remind participants that the goal is not to figure out who said what but, rather, to share thoughts and feelings of their own that are similar to what is on the card. Usually there is some part of the experience with which others can identify. Hopefully, this affirmation will help the author feel less alone and make what was once a "secret" open for discussion with others.

DISCUSSION:

Larson discusses what might be some of the origins of helper's secrets. These ideas might be useful to introduce during the group discussion.

Tendency toward self-blame: People who are near "burnout" often blame themselves for their problems and their struggles. They look for inadequacy in themselves when they fail with a patient or do not me their goals.

Unrealistic self-expectations: Questioning oneself and the work that one does is inevitable when helping others. Yet, expecting to meet all the needs and wants of every client is unrealistic. Expecting too much of oneself is a blueprint for defeat.

Differences Between Real and Ideal Images of Self as Helper: The ideal caregiver is perhaps seen as other oriented and all giving. In reality, this approach causes feelings of overload, anger, and "what about me" - feelings that the idealized "good caregiver" should not have.

"Good" caregivers are in control and don't have strong negative feelings such as these - or at least don't talk about them. Criticizing oneself for having these feelings only increases their stressful effect.

The Fallacy of Uniqueness: We tend to believe that we are likely the only caregiver who feels this way. The irony is that some, if not all, of the co-workers have experienced some of these frustrations.

Antidotes: Larson feels that helper's secrets are best shared with someone who does the same type of work - someone who can have instant empathy. To learn that you are not the only one who feels a certain way can be a comfort. To see that others have difficulty in situations that trouble you helps bring about more realistic expectations of self. Difficult feelings can be worked through and thereby made more normal. Discussion helps correct the "bias toward self-blame so that energy can be directed to developing better coping and problem solving skills".

CARE FOR THE CARETAKER

1. Be gentle with yourself!

2. Remind yourself that you are an enabler not a magician. We cannot change anyone else - we can only change how we relate to them.

3. Find a hermit spot. Use it daily.

4. Give support, encouragement and praise to peers and to management. Learn to accept it in return.

5. Remember that in the light of all the pain we see, we are bound to feel helpless at times. Admit it without shame. Caring and being there are sometimes more important than doing.

6. Change your routine often and your tasks when you can.

7. Learn to recognize the difference between complaining that relieves and complaining that reinforces negative stress.

8. On the way home, focus on a good thing that occurred during the day.

9. Be a resource to yourself! Get creative - try new approaches. Be an artist as well as a technician.

10. Use supervision or the buddy system regularly as a source of support, assurance and re-direction.

11. Avoid "shop talk" during breaks and when socializing with colleagues.

12. Schedule "withdrawal" periods during the week - limit interruptions.

13. Say "I choose" rather than "I should, I ought to or I have to". Say "I won't" rather than "I can't".

14. If you never say "no" - what is your "yes" worth?

15. Aloofness and indifference are far more harmful than admitting an inability to do more.

16. Laugh and play.

Source: Camille Wade Maurice, Camille Wade Maurice Associates, 1978.

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Appendices

Appendix I shares the training format developed by one of the GERO instructors. This works well when you have the same group for the entire program. It is offered as an example of how several different learning experiences can be combined for a workshop.

Appendix II is an article written for the OUTREACH NEWSLETTER. The response from readers was so positive, it is included here for your information. Knowledge of the needs of people with specific diseases can help create an atmosphere that prevents difficult situations from occuring.

APPENDIX I

UNDERSTANDING DIFFICULT BEHAVIOR

THREE HOUR TRAINING FORMAT

This learning experience combines several of the elements of previous exercises into an interactive format suitable for small groups. Originally designed for three one hour sessions, it can be easily adapted for a half day workshop. The worksheet was developed as a guide to the participant in a thinking process that would generate discussion in the following areas:

The nature of difficult behavior in the long term care setting;

The dynamics of the relationship between resident and staff that contribute to difficult behavior;

The therapeutic role of the caregiver.

METHOD:

Each participant is given a copy of the worksheet and advised that these are for use during the workshop and will not be collected. If the program will be conducted over several meetings, ask that they bring the sheets back with them to each session. Assure participants that the sheets will not be collected. Rather, they are offered as a way of tying together several different factors relating to behavior in the long term care environment. Encourage them to draw on their personal experiences in caring for the elderly, rather than trying to come up with the "right" answers. The worksheet is merely the framework upon which they build with the richness of their experience and insight.

A facilitator's guide for the worksheet is included. Since each part of the program builds on the last, it is recommended that you proceed in the established order. The time allotted for each section depends upon the participation of the group. In general, it takes about three hours to work through the entire sheet.

UNDERSTANDING DIFFICULT BEHAVIOR WORKSHEET

INSTRUCTOR'S GUIDE

The learning experiences contained in these programs emphasize small group work. The seating arrangment that lends itself best to this format is groups of four or five participants seated around tables. Provide a worksheet for each person.

WARMUP EXERCISE

The learning experience entitled "Choosing Your Assignment", (Section 2) is used as a warm up exercise before beginning the worksheet.

BEGINNING THE WORKSHEET

LOSSES

The facilitator asks the group to think about the residents they care for and consider the losses they have sustained that has required them to move to a long term care facility. Ask them to list as many as they can think of in the "loss column" and discuss their list with others in their group. After alloving the group about three minutes, ask that they share their list. The facilitator should duplicate the worksheet columns on a flip chart or blackboard, listing and discussing losses as they are offered by the group (i.e. home, family, independence, money, etc.).

FEELINGS

The facilitator asks participants to describe the feelings the residents might be experiencing as a result of these multiple losses. Proceed as above (lonely, discouraged, useless, frustrated, etc.).

VIEW OF SELF

This is an appropriate place for the facilitator to lead an informal discussion on self esteem. How is self esteem developed? Can it be destroyed? How? How is it related to behavior? Refer to the background material on self esteem and behavior found in section 1 of the manual.

BEHAVIOR

As caregivers, we have not seen the losses accrue, we cannot "see" the feelings nor have immediate insight into the resident's self-concept. We do, however, see and experience them in the various behaviors we deal with each day. Ask participants to describe some of the behaviors they encounter in their work? Which of these behaviors are especially difficult to deal with? Proceed as before listing various behaviors.

There are three important lessons we can carry away from this exercise. They are the following:

1. If we are to be effective in dealing with the behavior, then the feelings behind the behavior must be addressed.

2. If we knew the way people view themselves, we would better understand why they act as they do.

3. All behavior has meaning.

Instructor Note - One of the primary goals of this exercise is to help the hands on caregiver develop an elevated view of their role. In illustrating that there are more dimensions to behavior than just one, the caregiver understands that their role involves more than simply responding to behaviors. It requires the qualities of sensitivity and empathy as well as observation and assessment skills.

UNIVERSAL NEEDS

We have just noted that "all behavior has meaning". Another way of saying this is to say "all behavior is purposeful". Even though the meaning may not be readily apparent to the staff, it serves a purpose for the one who is using it. What is the purpose? We use purposeful behavior to get needs met.

To begin this discussion on the psychosocial needs of the elderly, the facilitator should conduct learning experience entitled "Universal Human Needs" with the group (Section 1). After the experience is completed, the facilitator should share with the group these three "all inclusive" universal needs.

INCLUSION - In order to retain an interest in life, there must be involvement in its process. We all have a need to be included, as opposed to being excluded from what goes on around us.

AFFECTION - Every person needs to feel cared about, to have a sense that they are valued by others.

CONTROL - Essential to a healthy self concept is the right to make ones own choices. It is particularly important to be involved in decisions concerning one's treatment and care.

In the institutional setting, the resident needs to be included, to feel cared about, and to have a measure of control over his life. Often the needs of the resident may conflict with the needs of staff. For example, meeting the residents need for inclusion and affection may create a real crisis for the caregiver working under time constraints or working short staffed (which affects his or her sense of control over the situation). All caregivers have probably experienced conditions that made it difficult for residents needs to be met. At those times, it may have seemed that residents behaviors reflected a greater urgency to get their needs met.

THE MANIPULATIVE CYCLE

When circumstances make it difficult to get needs met, people often resort to manipulation as a means of getting what they want. It is important for participants to discover how their own responses to difficult behavior may constitute manipulation toward the resident. Understanding how they may contribute to the cycle is critical to implementing change.

See background information in section 2 of the manual, "The Manipulative Cycle".

Note - Case study on Manipulative behavior in section 2 may be used here.

WHAT THE RESIDENT DOES NOT LOSE

Often, when working with people with a mental impairment, caregivers do not exercise the same degree of sensitivity as with those who are not impaired. Perhaps there is a sense that cognitive loss somehow renders these residents incapable of perceiving this lack of deference. It is important for caregivers to be aware of abilities that remain with the resident, even those cognitively impaired. According to Edelson, (1988) the following remain.

1. A FULLY INTACT EMOTIONAL CAPACITY
2. AN AWARENESS OF THE ENVIRONMENT AND CHANGES OCCURING WITH IT
3. SOCIABILITY
4. SOCIAL SKILLS
5. A WAY OF COMMUNICATING
6. ABILITY TO MAKE LOGICAL CONNECTIONS, (even if inaccurate)

Note - For background information, refer to "Mentally Impaired Resident", found in section 2 of the manual.

COMMUNICATION

In section one, we noted that self esteem is undermined by the barrage of daily messages that tell the resident how he/she is perceived by others. The way others view us actually becomes the mirror through which we develop a perception of ourselves. Residents who perceive themselves as being liked by the staff, for example, will respond much differently toward others than those who believe nobody likes them. To discuss sending positive messages through verbal and non-verbal communication, refer to the background material on "communication", in section 3 of the manual.

COUNSEL TO NEW EMPLOYEE, WHAT PRECIPITATES DIFFICULT BEHAVIOR

In this section the facilitator discusses being a therapeutic caregiver by involving the group in the learning experience on page 43. This learning experience utilizes the collective experience of the caregivers participating in this workshop and always generates more than ample discussion material.

Note - This completes the worksheet. As suggested, this format usually involves three one hour sessions. A fourth session always follows, it's contents include:

1. Learning Experience_"Problem Solving" model in Section 3
2. A discussion utilizing the "Caring for the Caregiver", material found in section 3 of the manual.

UNDERSTANDING DIFFICULT BEHAVIOR WORKSHEET

LOSSES	FEELINGS	VIEW OF SELF	BEHAVIOR

LESSONS

1.

2.

3.

PURPOSEFUL BEHAVIOR IS USED TO....

UNIVERSAL NEEDS = 1. 2. 3.

STAFF RESIDENT MANIPULATIVE CYCLE	COMMUNICATION
WHAT THE RESIDENT DOES NOT LOSE 1. 2. 3. 4. 5. 6.	WORDS ___ % VOICE TONE ___ % BODY LANGUAGE ___ % LISTENING SKILLS 1. 2. 3. 4. 5.

COUNCEL TO NEW EMPLOYEE = WHAT PRECIPITATES DIFFICULT BEHAVIOR

ALL RESIDENTS	DEMENTIA	DEPRESSION	PARANOIA	HALLUCINATIONS/ DELUSIONS

APPENDIX II

HANDOUT

ACTIVITIES WITH ALZHEIMER'S: A BRIEF OVERVIEW

A foundation of effective Alzheimer's care rests on thinking of "activities" as, "everything a person does in 24 hours a day".

> **An important concept of daily life with Alzheimer's is the "wind-up" principle: if an Alzheimer's individual is left alone for long, he/she will "wind-up", becoming agitated, angry, terrified, etc. Each individual is different, and today will not be just like yesterday. Most folks, though, will need to be "active" at least about every 45 minutes.**

Management of Alzheimer's-type behavior often means helping folks stay busy enough, without becoming overtired. Most problem behavior is the result of poor management by staff. That often means too little "busy-ness", or too much.

This needs teamwork. Activities can't be what staff does when all their "real" work is finished; it can't be "extra".

Of course there is a difference between AM care and a hike in the woods; between peri-care and a visiting musician; between eating a regular meal and helping to prepare a sandwich/"picnic" lunch. However, the basic "Do's and Don'ts" are the same.

Organized, structured activities that "work" with Alzheimer's should be:

Familiar

It should be "nothing new", something the person has done over and over, like chopping vegetables, raking leaves, or sweeping the floor. Music, sayings, "current events", should be what the person knew before their dementia set in.

Successful

It should be something the person can do without frustration, yet not so simple as to seem "baby-ish".

Motivating

A task, or entertainment, should look good: it should be interesting; it should seem useful; it should be something "helpful". Often, the most important thing a caregiver can think is, "What can someone do to help me now?"

Chosen

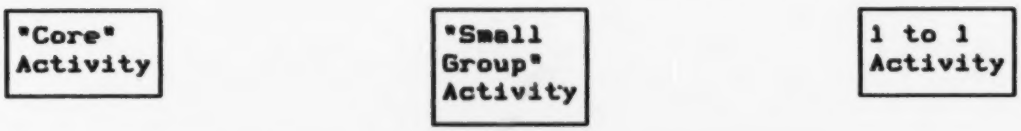
The individual should feel that it's their choice, their idea to do this. Sometimes a choice not to do something can work wonders.

An activity that works is often one that tickles folks' "funny bones" as well. We learn to laugh, to smile, very early, as babies; it's a skill that often lasts long into the disease. Folks do love to laugh, and feel better for it.

No one activity will fit everyone, ever. More than one activity will often have to be going on at the same time. This "parallel" programming often begins with a "core" activity, or one that includes "most" folks. Once this group is underway, there will probably be a need for smaller-group activity as well.

A period of simultaneous activity may well consist of several small groups. However, there may still be some folks who are not involved. They will then require individual (one-to-one) activity.

Here is the idea:



A few examples of each type group:

1. "Core"

Group exercise, walks, discussion/mental-stimulation groups, sing-a-longs, entertainments, demonstrations, adapted sports and games, slide programs, etc.

2. "Small Group"

Food preparation (peeling/chopping/slicing/spreading/stirring); modified table games (including card games for 'card players') magazine 'scavenger hunts', puzzles, books and pictures for "browsing", simple art projects, arranging flowers; traditional chores, such as folding towels, linen, and napkins. "Sorting" tasks can be easily geared to individual interests and abilities. A few examples would be socks, hard candies (in wrappers), poker chips, artificial flowers, teacups and saucers, pipe cleaners, bows, labeled envelopes, stickers, baseball cards, etc.

Busy-work is wonderful - the more time-consuming, the better, as long as it doesn't feel like busy work!

3. One-to-One

Most of the above activities can be used with an individual as well. Other 1-to-1 ideas include such chores as dusting, washing tables, making beds, washing dishes, sweeping, raking, garden work, "busy boxes" and pet care. "Winding" tasks are especially useful for a person sitting down, and can range from Christmas garlands to ribbon on a roll to rope on a spool to the traditional balling yarn. A simple board with holes drilled for different sized nuts and bolts can be very involving.

Children's toys and games can be very valuable. If an item is plain (without "baby-ish" pictures), colorful, and of an appropriate mental-level, then it is likely to appear challenging.

Extras in personal care can be a natural part of regular ADL's: a little extra make-up; a manicure; a gentle massage, a back-scratch. Often, a resident enjoys returning "the favor" to the caregiver!

Sometimes, of course, the most valuable activity of all is simply sitting with a person, or walking with them, or sharing a cup of coffee.

It is important to keep in mind that activity - "parallel" or not, should not be constant. A "busy" time should be followed by a "quiet" time.

In the end, it usually takes far more staff time to calm a person down - and those whom they have agitated in turn - than to keep folks "busy and calm" in the first place. As one resident of the A.C.C. said recently, "You know, time flies...when you're busy. Then you don't get nervous."

No two of us are exactly alike; dementia affects everyone differently. Our skills in coping with those entrusted to our care is limited only by our ingenuity, both as individuals and as a team. Our success depends on knowing the individual, and the individuals.

by James Dowling, Activities Specialist, Alzheimer's Care Center

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